MassHealth 1115 Demonstration Project
Annual Report SFY2003

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Abbreviations

AHEC	Area Health Education Center
AIDS	Acquired Immuno Deficiency Syndrome
ATS	Acute Treatment Services
BEI	Billing and Enrollment Intermediaries
BHP	Behavioral Health Program
BMC	Boston Medical Center
BSI	Bureau of Special Investigation
CAHPS	Consumer Assessment of Health Plan Survey
CCRC	Continuing Care Retirement Community
CFFC	Coordinated Family Focused Care
CHCS	Center for Health Care Strategies
CHEC	Community Health Employment Connection
CHPR	Center for Health Policy and Research
CLAS	Culturally and Linguistically Appropriate Services
CLPPP	Child Lead Poisoning Prevention Program
CMR	Care Monitoring Registry
CMS	Center for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
CPU	Central Processing Unit
CSHCN	Children with Special Health Care Needs
CSM	Contract Status Meeting
CTR	Clinical Topic Review
DET	Department of Employment and Training
DHCFP	Division of Health Care Finance and Policy
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DMH	Department of Mental Health
DMR	Department of Mental Retardation
DOE	Department of Education
DOR	Department of Revenue
DPH	Department of Public Health
DSS	Department of Social Services
DTA	Department of Transitional Assistance
DYS	Department of Youth Services
EAEDC	Emergency Assistance to Elderly, Disabled and Children
EBR	Employee Benefits Resources
ECS	Electronic Claims Services
ED	Emergency Department
EI	Early Intervention
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESI	Employer Sponsored Insurance
FAP	MassHealth Family Assistance Program

FFY	Federal Fiscal Year
FFP	Federal Financial Participation
FPL	Federal Poverty Level
GPRA	Government Performance Results Act
HAN	Health Access Network
HBA	Health Benefit Advisor
HCFA	Health Care Finance Administration
HEDIS	Health Plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
IP	Insurance Partnership
MA21	Massachusetts Eligibility Computer System
MAAGPAC	MassHealth Adolescent Anticipatory Guidance Public Awareness Campaign
MAP	MassHealth Access Project
MassPRO	Massachusetts Peer Review Organization
MBHP	Massachusetts Behavioral Health Partnership (the Partnership)
MBR	Medical Benefit Request
MCAAP	Massachusetts Chapter American Academy of Pediatrics
MCO	Managed Care Organization
MDS	Minimum Data Set
M&E	Monitoring and Evaluation
MEC	MassHealth Enrollment Center
MEQC	Medicaid Eligibility Quality Control
MHA	Massachusetts Hospital Association
MHQP	Massachusetts Health Quality Partnership
MHSPY	Mental Health Services Program for Youth
MIP	Massachusetts Immunization Program
MIT	Medical Interpreting Training
MMIS	Medicaid Management Information System
MMIG	Massachusetts Medicaid Infrastructure Grant
MMS	Massachusetts Medical Society
MSIS	Medicaid Statistical information System
MSP	Medical Security Plan
NCQA	National Committee for Quality Assurance
NEP	Northeast Partnership
NHLBI	National Heart, Lung, and Blood Institute's
NHP	Neighborhood Health Plan
Partnership	The Massachusetts Behavioral Health Partnership
PCP	Primary Care Physician
PCG	Public Consulting Group
PIMS	Performance Improvement Management Services
PQIP	Perinatal Quality Improvement Project
QI	Quality Improvement
QIP	Quality Improvement Projects
QIS	Quality Improvement Specialist

RC	Rating Categories
REVS	Recipient Eligibility Verification System
RFR	Request for Responses
RID	Recipient identification
RNM	Regional Network Manager
RWJ	Robert Wood Johnson
SBHC	School Based Health Center
S-CHIP	State Children's Health Insurance Program
SFY	State Fiscal Year
SSI	Supplemental Security Income
SSTA	State-to-Sate Technical Assistance
STD	Sexually Transmitted Disease
SUMARC	Support Materials Review Committee
TANF	Temporary Assistance for Needy Families
TWWIIA	Ticket to Work and Work Incentives Improvement Act
WIC	Women Infants and Children

I. Executive Summary

During FY03, the Commonwealth faced significant fiscal difficulty as a result of the current state of the economy. Despite this, the MassHealth program remained largely intact, although some cost cutting measures were necessary. The Commonwealth was able to maintain its commitment to providing quality care throughout the MassHealth program, minimizing the impact of necessary benefit changes in spite of limited resources. These changes were made while placing a priority on preserving eligibility to the extent possible. In January 2003, the Commonwealth eliminated certain optional services for adults on MassHealth. In March 2003, premiums to MassHealth members in Family Assistance and CommonHealth members were increased. The most significant cut occurred in April 2003, when eligibility for the MassHealth Basic program was greatly curtailed, resulting in the loss of coverage for approximately 40,000 MassHealth Basic members. Fortunately, the Commonwealth was able to restore benefits to most of this population in October 2003.

The period from July 1, 2002 – June 30, 2003 marked the 6th year of the Massachusetts 1115 Demonstration Project (the Demonstration), and the 1st year of the 3-year extension of the waiver. As of June 30, 2003, 791,660[1] individuals were enrolled in the MassHealth Demonstration. This represents a 42% increase in enrollment since the implementation of the Demonstration on July 1, 1997 and coverage for an additional 234,288 Massachusetts residents. However, the June 30, 2003 caseload indicates an 8% decline in enrollment since June 30, 2002. Over half of this decline can be attributed to the reduction of the Basic program. Most of the remaining decline in caseload occurred in the Standard population.

The budget crisis is expected to continue in FY04. The Commonwealth plans to take several steps to slow the growth of program costs. Anticipated changes include increasing member cost-sharing, placing a cap on the caseload of adults in expansion populations and continuing a MassHealth Drug List to steer members to lower cost pharmaceuticals. Such changes will be necessary in order to create a program that is sustainable with the current level of financial resources.

During FY03, the Commonwealth began a multi-year process to reorganize state government. This process involves extensive restructuring of the Commonwealth's Executive Office of Health and Human Services (EOHHS). Under this reorganization, EOHHS will become the single state agency responsible for the Medicaid program. This reorganization will streamline delivery systems at the state level, enabling the Commonwealth to better coordinate benefits provided to MassHealth members. Restructuring EOHHS has been a cross-agency effort, and has therefore demanded considerable attention and energy of agency staff. This initial investment of human resources is expected to result in a more efficient and more effective delivery of

[1] This number includes 15,442 state-only funded, non-qualified alien MassHealth members enrolled in various eligibility groups.

services to all Commonwealth residents. The process of restructuring is expected to continue to require the attention of many MassHealth staff members in the coming year.

Despite fiscal constraints and the need to focus on agency reorganization, the Commonwealth continues to expand its focus on coordinated quality health care. During FY03, MassHealth strengthened efforts to provide access to quality behavioral health services for members. For example, the Commonwealth implemented a grant funded by the Robert Wood Johnson Foundation to improve treatment of depression in primary care. Additionally, the Commonwealth has continued to use the behavioral health contract as a venue to further integrate PCC and behavioral health network management. Through this contract, MassHealth has increased care coordination across medical services and behavioral health services, worked to strengthen the professional link between PCCs and behavioral health providers and increased educational outreach for PCCs on behavioral health issues.

Both the PCC Plan and the MCOs continue to direct efforts on monitoring and improving quality. In FY03, the PCC Plan participated, for the first time, in the Independent External Quality Review (Clinical Topic Review) (CTR). The results from this review, combined with information from HEDIS data, will be used to develop future quality improvement goals. Similarly, the MCO program continues to focus its quality improvement and measurement activities. The Commonwealth monitors quality in the MCOs through MCO contract status meetings, member satisfaction surveys, HEDIS measures, and clinical topic reviews.

II. Introduction

This draft Annual Report describes activities in Year Six of the Demonstration in accordance with term and condition number 57 of the Special Terms and Conditions of the MassHealth Demonstration (Project Number 11-W-00030/1) that accompanied the approval letter for the Demonstration. In April 1995, the Health Care Finance Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS), approved a five-year Medicaid research and demonstration waiver for the Massachusetts Division of Medical Assistance (the Division) under authority of Section 1115 of the Social Security Act. The Commonwealth implemented the 1115 Demonstration Waiver in July 1997. SFY03 is the first year of a three-year extension of the waiver.

The report highlights activities and developments during the sixth year of the Demonstration in the areas of outreach and marketing, eligibility, enrollment in health plans, service delivery and access, Family Assistance and the Insurance Partnership, quality assurance, and other issue specific areas. Year six saw the continuation of various activities related to the waiver as described in this report and previous years' reports.

III. Member Outreach, Marketing and Education:

The Member Services Unit oversees MassHealth member services activities; which include, but are not limited to a high volume customer service telephone line, which receives an average of 3500 calls daily and received over 1.2 million customer calls in SFY03.

Other Member Services Unit responsibilities include:

- Targeted Outreach and Member Education
- Management of the Medical Benefits Request (MBR) application process
- Determination of eligibility and review of continued eligibility
- Selection of and enrollment into a health plan
- Communication with members
- Assuring cultural competency and cross cultural awareness
- Development of enrollment materials in conjunction with the Enrollment Broker
- Operation of a customer service telephone line
- Establishment of electronic search engines for the Medical Library by title and subject

The Division's primary customer is the MassHealth member, and the Division's Member Services Unit embodies that philosophy.

The Targeted Outreach/Member Education group within the Member Services Unit is primarily responsible for identifying underserved communities and populations and developing targeted efforts to provide education about the availability of MassHealth benefits.

Targeted Marketing Strategies: In SFY03, the Division continued to pursue strategies to increase enrollment in MassHealth among targeted groups. Reaching the parents/guardians of uninsured children continued to be an important focus of these efforts. Target strategies to reach those who are eligible for MassHealth are highlighted below. In SFY03, the Division continued production of a quarterly "Community Connections" publication to all community MassHealth providers and advocates. The publication is designed to provide communities across Massachusetts with the most up to date information about MassHealth programs, services, and policies that could affect MassHealth members. Feedback from community-based organizations has been extremely positive.

(See attachment 1 for copy for *Community Connections*)

Marketing and Outreach to linguistically and culturally diverse populations: The Division continued to promote linkages and coordination for ethnic multi-media opportunities in SFY03. Outreach efforts included print, TV, and radio advertisements to targeted

populations (e.g., Latino, Portuguese, Cambodian, Russian, Chinese) to learn more about available MassHealth services. In addition, for the fifth consecutive year, the Division has contracted with the University of Massachusetts Medical School to train over 300 employees of MassHealth contracted ambulatory care providers to serve as bilingual interpreters for the non-English speaking populations at their facilities.

Partnering with Our Schools: The Division's school-based outreach activities for children and families continued to be:

MassHealth Informational Flyer: For the sixth consecutive year, DMA produced over 1 million MassHealth informational fliers for distribution to children enrolled in childcare settings, public, private and parochial schools in Massachusetts. However SFY03 budget constraints and school deadlines prevented flier distribution. As a result, implementation of the school flier campaign has been rescheduled until the SFY04 school year.

Ongoing school outreach activities include the following:

- Continuing to encourage Massachusetts schools to actively review a child's health insurance status at appropriate opportunities within the school year (e.g., kindergarten registration, school transfers);
- Maintaining efforts to promote the inclusion of a question about the child's health insurance coverage on the student emergency card maintained by the school;
- Continuing support of collaboration with local health care access project grantees to provide information and assist families with health insurance enrollment.

Covering Kids and Families: Massachusetts is a Robert Wood Johnson Foundation *Covering Kids'* site. In SFY03, the Division maintained its commitment to work closely on this effort with its state sponsor, *Health Care for All*, a Boston based health care advocacy organization. Active collaboration exists between both organizations, with shared data and information.

Boston Area U.S. Post Office Pilot Project: For the second year, MassHealth Application Displays, promoting the availability of free or low-cost health care, were placed in many Boston and North Shore U.S. Post Office Branches. Each display box contained a number of MassHealth applications and informational brochures. As the Division provides outreach materials in 10 languages (Spanish, Portuguese, Chinese, Vietnamese, Haitian Creole, Russian, Cambodian, Laotian, French, and Arabic), brochures were available in both English, as well as the language(s) spoken in the specific community.

Hispanic/Latino Initiative: As in previous years, reaching the state's eligible Hispanic/Latino population continued to be a top priority in SFY03. The Division's sponsorship of special television public information programs on the most notable Hispanic television network in the United States, Univision New England, includes

special documentaries and public service announcements throughout the year. This is an example of collaborations that the Division continues to engage in to increase awareness in the Hispanic/Latino communities about MassHealth and to encourage enrollment and education. Other activities include bilingual in-house publications, and collaborations with Hispanic/Latino internet marketing, television, radio, and print media.

Medical Community Effort: The Division continued to work closely with the Massachusetts Hospital Association (MHA), the Massachusetts Medical Society (MMS), and the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) to promote the state's MassHealth program. Additionally, MassHealth enrollment kits ("What to Do When an Uninsured Child Shows up at Your Door") were widely distributed.

Promotional Materials and Literature: In SFY03 the Division continued to distribute MassHealth promotional items, or "give-a- ways", on a limited scale. These items, all of which bear the MassHealth logo and toll-free telephone number, included pens, magnets, Rolodex cards, emergency phone cards, Post-it notes, Frisbees, water cups, jar openers, electric plug covers, magnet frames, and other items. Intermediaries who, in turn, promote the availability of MassHealth to the populations they serve primarily distributed the items for use to MassHealth populations at health fairs and various community forums.

Certain Member Education and outreach materials have been translated into the following languages: Spanish, Portuguese, Chinese, Vietnamese, Haitian Creole, Russian, Cambodian, Laotian, French, and Arabic. These are the languages predominately spoken by MassHealth members, as indicated by MassHealth's member eligibility system, MA-21, data.

Area Health Education Centers Regional Meetings: To support Member Education efforts, DMA continued to provide funding for the Health Access Networks (HAN). HAN was developed in partnership with the University of Massachusetts Medical School's Area Health Education Center (AHEC) as a forum to share information, strategies and experiences on effective Member Education practices. HAN have been established since 1998 in each of the six regional areas and continued to meet monthly during SFY03. The meetings currently promote information dissemination, sharing of best practices, and building of community/public sector linkages to increase targeted outreach and Member Education information about MassHealth.

Customer Service*:* Below are three key areas of customer service activity, as seen from the perspective of a MassHealth member.

Information, Referral, and Assistance: Individuals interested in finding out about MassHealth are directed to the MassHealth Customer Service Center's toll-free 800-telephone number. This phone number is operated by MAXIMUS, a contracted vendor. In addition to providing customer service to all MassHealth members or potential members, MAXIMUS, the vendor operating the Customer Service Center, is also

responsible for two other functions. As an enrollment broker, MAXIMUS is responsible for educating and providing neutral third party counseling about the various health plan options into which a MassHealth member must enroll. The Enrollment Broker also arranges for non-emergency, medically necessary transportation for MassHealth members.

The Customer Service Center has telephone capability from 8AM to 5PM, Monday through Friday, including TTY service for the hearing impaired. Over 51% of the Customer Service Center staff speaks another language in addition to English. In addition, AT&T interpreting services are available in instances when other language capacity is needed. MAXIMUS is contractually required to answer 4,320 telephone calls daily. At peak times the number of calls received at the Customer Service Center has been greater than 7,000. During the past year the average monthly call volume decreased .9% from 106,312 calls in SFY02 to 105,212 in SFY03.

Health Benefit Advisors at the Customer Service Center are trained to respond to inquiries about MassHealth, send out applications to those who are interested in applying, and refer calls appropriately. There are six Community Representatives in the field, plus a supervisor. These representatives are MAXIMUS employees. Each of the MassHealth Enrollment Centers (MECs) serves as a base for a Community Representative. The other two Community Representatives are assigned to Managed Care Organizations (MCOs): BMC HealthNet and Network Health.

Eligibility Maintenance: The MECs manage and supervise all customer service activity that is related to eligibility and case maintenance. The MECs received over 1.2 million customer calls in SFY03. There are four geographically located MECs in the state staffed with eligibility representatives trained to help MassHealth applicants once they have applied for benefits through the MassHealth Central Processing Unit (CPU) in Charlestown. The MECs respond to case specific questions regarding maintaining eligibility for the duration of an individual's MassHealth membership and are located in Revere, Springfield, Taunton, and Tewksbury.

Customer Service Training: Division and MAXIMUS staffs receive ongoing training about eligibility changes, new benefit programs, and implementation of all MassHealth expansions. Training enables staff to respond to customer contacts and make appropriate referrals. In addition, staff receives detailed operational memoranda that describe policies and procedures related to the expansion.

The Division's Human Resources unit works to ensure eligibility workers receive training in existing eligibility policy and related systems as well as new eligibility changes introduced. The Division utilizes an extensive 10-day training for both new MassHealth eligibility workers and those who assumed Health Care Reform eligibility duties after having worked in a different area of MassHealth. The training includes the basics of health care reform policy, detailed explanations of coverage (including the Insurance Partnership program), understanding a member's citizenship, and the basics of all eligibility-related computer systems, including MA21, Medicaid Management Information

System (MMIS), and Recipient Eligibility Verification System (REVS). The Division also offers refresher courses, job aids and other learning tools on these computer systems, applicable regulations and policies, as well as areas where workers request additional training or assistance. The MECs have their own trainers who work with the Division's Human Resources unit to provide training and guidance. In SFY03, the Division targeted training on:

1) Verifying Health Care Reform members' earned income;
2) Preventing "Shared" Social Security numbers and understanding how MMIS and MA21 interact;
3) Department of Revenue (DOR) Profiling;
4) Disability verifications, and
5) Cross training, in Health Care Reform for MEC staff who had previously worked in other areas of MassHealth.

Customer Service Quality Initiatives: Throughout SFY03, the Quality Improvement Specialist (QIS) staff housed at each MassHealth Enrollment Center (MEC) and at the Central Processing Unit (CPU) continued their efforts toward improved customer service. QIS staff attended occasional statistical analysis and customer service training sessions to develop new skills and to enhance skills they already had. Once again in SFY03, QIS staff undertook individual projects at the MECs and the CPU to address issues ranging from initial customer contact to behind-the-scenes activities that impact delivery of customer service. These are examples of the SFY03 projects:

Revere MassHealth Enrollment Center:

- Analysis of call distribution
- Validation of Private Health Insurance Premium Payment for Long-Term Care Cases
- Caseload Data Integrity
- Second Level Review (Team manager reviews application for accuracy completed by staff member.)
- Express Renewal
- DOR Match Processing

Springfield MassHealth Enrollment Center:

- Medex Cost Savings
- Home Maintenance Allowance
- Insurance Partnership Coordination
- Recipient Identification (RID) Case Resolution

Taunton MassHealth Enrollment Center

- Bureau of Special Investigation (BSI) Fraud (BSI reviews case load integrity)
- Nursing Home Medical/Dental Deduction Tracking
- Workflow and Statistical Tracking

Tewksbury MassHealth Enrollment Center:

- Development and implementation of the Department of Mental Retardation (DMR) conversion process
- A pickle process set up which included creating a macro on the system to assist in pickle calculations. (Senator Pickle from Texas passed the bill which primarily prevents some members from losing MassHealth simply due to the fact they lost Supplemental Security Income (SSI))
- A shared RID problem was identified, a process to correct was implemented and training took place for staff.

Central Processing Unit:

- Insurance Partnership Program MBR Review
- Disability Supplement Workflow Study
- Disability Supplement Review for Health Insurance Portability and Accountability Act (HIPAA) Compliance
- Boston Medical Center (BMC) MBR Quality Analysis

In addition, each MEC continues to select one customer service quality improvement project, and periodically reports on progress in achieving its goals. The Division continues to review the outcomes from a procedural perspective as well as a customer service perspective, and if problems appear related to a particular procedure, the Division will review the procedure to see if changes can be made to ease process problems.

Cultural Competency: The Division continued to develop initiatives in the area of cultural competency. The Division defines cultural competency as "a developmental process that involves cognitive changes that begin with cultural awareness and end with the attainment of cultural knowledge, adaptation of attitude/behaviors, and the acquisition of skills to work effectively with customers from diverse linguistic and cultural backgrounds." In SFY03 MassHealth's Member Services has sponsored Division initiatives in partnership with the MassHealth Access Project (MAP) at the University of Massachusetts Medical School to continuously improve the quality of health care services available to all MassHealth members.

The Division continued to maintain the following initiatives in SFY03:

Cultural Competency in Adapting Materials for Latino Spanish-speaking members:
A committee comprised of representatives of the benefit plans including the MCOs helped in the pre-production of materials targeted to Spanish speaking members as part of the quality improvement project process. Booklets, television public service announcements, and a tool kit are the results of this process.

Cultural Competency Resource Center (CCRC): The Division maintains a physical and virtual Cultural Competency Resource Center to serve as a primary resource for Division staff to access data and information specific to all racial, ethnic and linguistic minorities served by MassHealth. It is staffed by a full time Health Librarian and part time Systems Librarian. Access to the CCRC is available to all Division staff via an icon

on their desktop. Intranet and Internet access will become available in the future. Over 800 holdings are available to Division staff and its stakeholders through the interlibrary loan process.

Member Education Web Site: A new section of the Division's Internet Web site currently under development is dedicated to Member Education that will include issues pertaining to Linguistic and Cultural Competency and its impact on receiving a quality health care outcome. This site will serve as an opportunity for MassHealth staff and providers to access health information designed to improve the quality of health care services available to individuals from all linguistic, ethnic, racial or cultural backgrounds.

C.L.A.S. Health Care Standards: The Division has developed and is awaiting implementation of policies and guidelines that will assist our managed care and fee for service health care providers in meeting the recommendations made by the U.S. Department of Health and Human Services Office of Minority Health's committee that developed national standards for culturally and linguistically appropriate services (CLAS) in health care.

Division Staff Training Activities: The Division provides ongoing information, awareness, and skill building opportunities to agency staff on diversity and cultural competency. Human Resources conduct ongoing diversity and cultural competency, whether it be workshops and/or cultural diversity luncheons, guest speakers etc.

Hospital Cultural Competency Quality Improvement Project: The Division requires evaluation and monitoring of quality indicators for cultural competency of all hospital providers contracted with MassHealth on an annual basis. The hospitals must maintain minimum performance standards by having a training/skill assessment policy and procedures to assure minimum competency skills in medical terminology, code of ethics and cross-cultural communication; and establish and maintain a data collection system and analysis of utilization to inform data driven quality improvement activity.

Medical Interpreting Training (MIT): In partnership with the MAPs at the University of Massachusetts Medical School, for the past five years, an introductory 15-hour and a comprehensive 54-hour MIT Program has been offered at hospitals, community health centers, and group practices throughout Massachusetts that serve MassHealth members. Over 1100 health care providers have successfully completed the MIT program as of June 2003. The goal of the program is to improve the medical interpreting skills of bilingual staff and/or volunteers that serve a minimum of 20% MassHealth members. In SFY 2003, over 300 newly trained ambulatory care medical providers have completed this medical interpreter-training program.

Health Disparities/High Risk Populations: This initiative continues to focus on educating high risk MassHealth members and the providers that treat them on the treatment/prevention of Diabetes, Sexually Transmitted Diseases (STDs), Asthma, and AIDS. The Quality Improvement Project (QIP) teams organized on these diseases have partnered with Member Services to bring information to the public at large through local

ethnic target media vehicles particularly among Latinos/Hispanic populations. Several sets or mini series of television health segments were produced on Diabetes, STD/HIV, cancer, cardiovascular diseases, and women's health issues prevalent among Latinos.

Critical MASS, a statewide coalition effort, strives to accelerate the elimination of racial and ethnic disparities by promoting a two-way flow of information so that providers and policy developers can learn from the affected communities and vice versa. Critical MASS implemented a statewide forum in June 2003 and has started to conduct a series of state regional forums to implement its mission, goals, and objectives. It was also the co-host of the New England Regional Minority Health Conference on March 2-4, 2003 in Boston, MA, which attracted over 200 participants.

MassHealth Translated Materials: The Division provides certain MassHealth materials in the following ten languages, in addition to English: Arabic, Cambodian, Chinese, French, Haitian Creole, Laotian, Portuguese, Russian, Spanish, and Vietnamese. These materials include MassHealth Member Eligibility Booklets and informational brochures.

IV. Eligibility

As of June 30, 2003 the MassHealth Demonstration population total was 791,660 [2] individuals, a decrease of 8% from June 30, 2002. (See Table 1) Since the beginning of the Demonstration there has been a 42.0% growth in the MassHealth Demonstration population. (See Chart 1)

These numbers, and all numbers within this section, include all children who receive MassHealth coverage through Standard, CommonHealth, or Family Assistance. Some of these children are State Children's Health Insurance Program (S-CHIP) eligible and Massachusetts receives enhanced Federal Financial Participation (FFP) through Title XXI for them, depending on family federal poverty level (FPL), insurance status at time of application, and other Title XXI requirements. The Division's overlapping authority, through a combination of its 1115 Demonstration and the Title XXI State Plan, allows for MassHealth coverage for all children at or below 200% FPL and disabled children of any income.

Eligibility by Coverage Types: The MassHealth Demonstration population is distributed among 6 coverage types, as well as the medical security plan which is operated by the Division of Employment and Training (DET). (See Chart 2) Under MassHealth, the Division has a variety of coverage types for members under age 65; coverage types are determined based upon financial and categorical eligibility. Applicants and members get the richest coverage type for which they qualify. The Division's significant expansion of coverage for children is accomplished through a combination of the Demonstration Project Waiver and S-CHIP.

MassHealth Standard provides benefits to children under age 19 whose gross family income is at or below 150% of the FPL, the parents of children whose gross family income is at or below 133% FPL, pregnant women and children under age one whose gross family income is at or below 200% FPL, and non-institutionalized disabled individuals whose gross family income is at or below 133% FPL. MassHealth Standard members receive the full Title XIX benefits package. Benefits are generally provided either through contracted Managed Care Organizations (MCOs) or through the Primary Care Clinician (PCC) managed care plan administered by the Division. As of June 30, 2003, 697,869 individuals were participating in MassHealth Standard accounting for 88% of the total Demonstration population. There was a decrease of 27,062 members for MassHealth Standard between June 30, 2002 and June 30, 2003.

MassHealth CommonHealth provides benefits to disabled adults, both non-working and working, and children who are not eligible for MassHealth Standard. There is no income limit for CommonHealth; however, non-working disabled adults are required to meet a one-time deductible before becoming eligible. CommonHealth members whose gross family income is greater than 150% FPL (approximately) are required to pay a

[2] This number includes 15,442 state-only funded, non-qualified alien MassHealth members enrolled in various eligibility groups.

monthly premium. The benefit package is very similar to that provided to members under Standard, except that it is generally provided on a fee-for-service basis. 14,871 individuals were participating in CommonHealth on June 30, 2003, representing 1.9% of the Demonstration population. There was an increase of 937 members between June 30, 2002 and June 30, 2003.

MassHealth Family Assistance provides benefits to children who are not eligible for Standard or CommonHealth, whose gross family income is greater than 150% FPL, but not more than 200% FPL. These children receive premium assistance toward qualifying employer-sponsored health insurance, when available. In certain cases, the Division also provides coverage for co-payments related to well-baby/well-child visits and other co-payments/deductibles after the out-of-pocket expenses for the children have exceeded 5% of the family's gross income. If there is no access to qualifying health insurance, children receive services through one of the Division's managed-care plans. The benefits are similar to those provided under Standard, with the exception of non-emergency transportation, day habilitation services, and personal care services. Monthly premiums have increased since SFY02. They are now assessed at $12 per child, with a maximum payment of $36 per family.

Family Assistance also provides premium assistance to certain adults who work for participating employers and have family incomes at or below 200% of the FPL. In addition to making premium assistance payments, the Division makes an Insurance Partnership (IP) payment to the participating employer to assist in the cost of the health insurance for low-income employees and their families. (See Section VII for more information on this program.)

Enrollment in Family Assistance began in August 1998, and there were 36,922 individuals participating in the program on June 30, 2003 accounting for 4.7% of the Demonstration population, an increase of 2.8% from the previous year. Of those enrolled, 9,077 were receiving premium assistance to purchase employer-sponsored insurance. Also as of June 30, 2003 there were 683 members enrolled in Family Assistance due to their HIV status under the HIV expansion. (See pg. 28 for further discussion on HIV expansion.)

Information on the number of policies purchased and the number of lives covered through Family Assistance Premium Assistance and the Insurance Partnership (IP) is discussed in Section VII.

MassHealth Basic: Prior to April 1, 2003, when eligibility criteria was changed within the state budget, the MassHealth Basic program provided benefits to adults who were long-term unemployed, with gross family income no more than 133% FPL. The MassHealth Basic program now provides benefits to all Emergency Assistance to Elderly, Disabled and Children (EAEDC) clients who are long-term unemployed with an income at or below 100% FPL and who are DMH members. Basic benefits are provided through managed-care plans for persons who do not have private health insurance. The benefit package does not include non-emergency transportation, adult

day health, adult foster care, day habilitation, hospice, personal care services, and private duty nursing. Persons who are otherwise eligible for Basic, but who had health insurance, receive MassHealth Buy-In. Through Buy-In, the Division pays for all or most of the cost of the member's private health insurance. As a result of the program change, there were 17,020 individuals participating in MassHealth Basic on June 30, 2003, accounting for 2.1% of the Demonstration population, a decrease of 71% from the previous year.

> *Next Steps:* On October 1, 2003 the MassHealth Essential program was implemented to fill the gap left by this program change. This new program will cover single and married childless adults, under age 65, who are long term unemployed and whose income is less than 100% FPL. The program is capped at 36,000 members.

MassHealth Limited provides emergency services, including labor and delivery, to undocumented aliens, who would otherwise be eligible for MassHealth Standard but for their immigration status. On June 30, 2003, there were a total of 24,564 individuals receiving MassHealth Limited, representing 3.1% of the Demonstration population. This is a decrease of 1,698 individuals since June 30, 2002.

> *Next Steps:* The number will increase substantially in SFY04 as more aliens with special status move to limited benefits only.

MassHealth Prenatal provides time-limited prenatal services to pregnant women who self-declare gross family income that is at or below 200% of the FPL. Once income is verified, these women become eligible for MassHealth Standard. 414 pregnant women were in MassHealth Prenatal Care on June 30, 2003. MassHealth provides presumptive eligibility to pregnant women with unverified income below 200% of FPL. The majority of women subsequently become eligible for MassHealth Standard. This represents an increase of 165 women since June 30, 2002.

Medical Security Plan: Individuals in Massachusetts who are unemployed, with income up to 400% of FPL, and who are receiving or are eligible to receive Unemployment Compensation Benefits may participate in the Medical Security Plan, offered through the DET. The DET contracts with Blue Cross Blue Shield of Massachusetts to administer the program and provide utilization management services. The Commonwealth receives FFP under the Demonstration for this program. (See Section VI for more detail.)

Table 1
Distribution of MassHealth Members by Eligibility Groups on June 30th for years 1997, 2002 and 2003

Eligibility Groups	June 30, 1997 Eligibility Groups as % of Total MassHealth Reform #	%	June 30, 2002 Eligibility Groups as % of Total MassHealth Reform #	%	June 30, 2003 Eligibility Groups as % of Total MassHealth Reform #	%	Change from Previous year to SFY03 (from SFY 02 to SFY03) #	%	Change From beginning of the Demonstration to SFY03 (from SFY 97 to SFY03) #	%
Standard	553,706	99.3	724,931	84.3	697,869	88	-27,062	-3.7	144,163	26.0
Basic			58,535	6.8	17,020	2.1	-41,515	-71.0	17,020	100.0
CommonHealth	3,666	.7	13,934	1.6	14,871	1.9	937	6.7	11,205	305.6
Family Assistance			35,907	4.2	36,922	4.7	1,015	2.8	36,922	100.0
Limited			26,262	3.1	24,564	3.1	-1,698	-6.5	24,564	100.0
Prenatal			249	<.1	414	<.1	165	66.3	414	100.0
Total MassHealth	557,372	100%	859,818	100%	791,660	100%	-68,158	-8.0%	234,288	42.0%

Note: These numbers include 15,442 state-only funded, non-qualified alien MassHealth members enrolled in various eligibility groups.

Growth by Age and Geography: The MassHealth Demonstration has had a significant statewide impact. Each Massachusetts County has seen a substantial increase in MassHealth enrollment; with a 32% increase on average for children and a 52% increase on average for adults. The largest percentage growth is seen in Dukes and Nantucket counties. The smallest growth is seen in Suffolk County.

Table 2
Medicaid Waiver Caseload by County – June 30, 2003

County	*Children* #	*Children* % change*	*Adults* #	*Adults* % change*	*Total* #	*Total* % change*
Barnstable	11,440	41.81	12,137	77.73	23,577	58.3%
Berkshire	9,494	43.9	9,682	63.7	19,176	53.3%
Bristol	41,224	39.1	41,156	60.7	82,380	49.1%
Dukes	785	160.8	826	168.2	1,611	164.5%
Essex	51,537	31.7	46,108	50.1	97,645	39.8%
Franklin	4,975	45.5	5,008	65.3	9,983	54.8%
Hampden	54,829	31.9	46,462	47.3	101,291	38.5%
Hampshire	6,325	43.0	6,863	64.62	13,188	53.5%
Middlesex	54,958	32.7	55,682	52.34	110,640	41.9%
Nantucket	240	137.6	236	159.3	476	147.9%
Norfolk	19,099	52.8	21,722	70.1	40,821	61.5%
Plymouth	27,571	38.2	24,974	60.1	52,545	48.0%
Suffolk	71,254	18.9	63,797	34.0	135,051	25.6%
Worcester	49,195	34.7	45,993	53.8	95,188	43.3%
Incorrect Zip code	1,992	-27.0	535	-38.1	2,527	-29.7%
Prenatal			414		414	
Total	404,918	32.2	381,595	51.6	**786,513	

*% Change is from implementation of the waiver on July 1, 1997
** Discrepancies from Table 1 in total MassHealth enrollment are due to difference in date on which data was aggregated.

Monitoring Changes in the Rate of Uninsured in Massachusetts:
The Division continues to monitor the rate of uninsurance in Massachusetts in order to assess the impact of the Demonstration. As of the date of this report, 2003 figures were not yet available. Surveys conducted during SFY02 by the Division of Health Care Finance and Policy (DHCFP) and the Current Population Survey (CPS) conducted by the Bureau of the Census were compared, as in previous years. It should be noted that differences in design, methodology, and timing of these surveys account for different results. In previous years, while there were discrepancies between the surveys in the magnitude of the uninsured

found in the state, there was concurrence in trends in the rate of uninsurance, which had been moving downward. In 2002, however, the DHCFP began to see an increase in the number of uninsured in the state, while the CPS continued to find a decrease in the total number of uninsured, and particularly for children.

Based on DHCFP's biannual survey conducted in 2002, the percent of uninsured increased slightly, by a half a percentage point (.5%) to 6.7 from the 2000 survey results. Children ages 0 – 18 continue to have the lowest rate of uninsurance at 3.2% (an increase of just under .5% from 2000), while the percent of uninsured adults increased from 8% in 2000 to 9.2% in 2002.

The CPS found that the total number of uninsured in the state had decreased to 8.2 % from 9.3% between 2001 and 2002. Similarly the number of uninsured children declined from the previous year, with 5.5% of children under age 19 found to be uninsured in 2002, while the number of adults (ages 19 to 64) increased slightly. CPS is currently analyzing 2003 data. Statewide numbers will be available soon.

The Division will continue to closely monitor changes in the rate of uninsurance in the state.

Up-Date on Operational Activities/ Operational Streamlining:

Applicants for MassHealth continued to benefit from a streamlined eligibility process during the sixth year of the Demonstration.

Submission of a Medical Benefit Requests (MBR): There are several ways that an applicant can file an MBR. MBRs are made available to potential applicants for easy access in a wide variety of locations, such as provider sites including hospitals, health centers, emergency service providers, other state agencies, and community-based organizations. There are several access points that an individual may use to submit an application for MassHealth benefits

The Division continues development of an "eMBR" that will allow for online submission of an MBR. The Division piloted the eMBR in a collaborative effort with Massachusetts General Hospital. Connectivity was successful in transmitting application information electronically from the remote site to the Division. Key enhancement requirements were also identified to develop the eMBR technology into one that will be meaningful in increasing access and efficiencies in the MassHealth application process.

> *Next Steps:* The Division is actively pursuing those enhancements and expanded rollout of the eMBR is planned in SFY04.

MassHealth Enrollment Centers (MECs): MECs are located in Revere, Tewksbury, Taunton, and Springfield. There is a single toll free 888 number that receives all incoming calls, which automatically refers the caller to the MEC

closest to the caller's location. MEC staff members are available to provide telephone assistance to individuals preparing an MBR for submission. MECs also receive MBRs, which may be submitted by mail, fax, or hand-delivered to one of the MEC locations.

Out-Stationed Eligibility Workers: The Division has out-stationed 2 eligibility workers at Cambridge Hospital and Boston Medical Center to assist MassHealth members with access to the application process.

Mail In: Approximately 88% of MBRs are mailed directly to the Central Processing Unit (CPU) without prior consultation of a MassHealth eligibility worker.

Processing MBRs: All applications received for non-institutionalized individuals under age 65 continue to be processed at the CPU. Each MBR is entered into the MA21 automated eligibility system, which determines whether or not the individual is eligible for MassHealth benefits, or whether additional information is needed.

The CPU received approximately 503 MBRs per day in SFY03, averaging 10,060 MBRs per month. In comparison, there was an average of 10,332 MBRs filed per month in SFY02.

Average turnaround time for MBR's was 11.8 days over the course of SFY03 as compared to 2.6 in SFY02. Staffing adjustments required due to an early retirement program, the impact of MassHealth Basic eligibility changes, and process changes required by HIPAA all contributed to an increase in MBR turnaround time in SFY03. The Division has been successful in adjusting to all of these factors. MBR turnaround time has decreased significantly since May 2003 and continues to trend downward.

All MBRs are processed immediately at the CPU. Sixty-five percent are received with all necessary verification information attached, while 35% require a request for additional information or verifications. Those with verifications attached are reviewed by eligibility staff and prepared for data entry. A simplified application form was introduced in 1997 and has been revised several times, most recently in the spring of 2003 at which time changes were introduced to the MBR for designation of persons authorized to act on behalf of and receive information about the eligibility of an applicant to ensure compliance with the HIPAA. (Attachment 2 up-dated MBR)

Improvements in the system for receiving and processing applications reflect the fact that Massachusetts has: (1) worked hard to develop a mail-in system as part of its expansion efforts, (2) increased the efficiency with which applications can be processed, and (3) standardized the outcome of eligibility determination

decisions. One important factor that has contributed to accomplishing these results is the refocusing of the eligibility worker's responsibilities. The eligibility worker remains responsible for working with the individual in the preparation of an MBR and clarifying and assuring the completeness of information received. The information is entered on MA21 and the system renders an eligibility decision. Consequently, eligibility workers have more time available to answer questions and to assist applicants with completion of an MBR

In SFY03 the Division processed a total of 102,607 applications (including new, re-application, and maintenance application). 89,026 were new MBRs. Of the new MBRs submitted in SFY03, 97% were processed and 3% were pending on June 30, 2003.

In SFY03 the Division performed annual eligibility re-determinations of approximately 183,127 households representing approximately 421,192 members. The Division also performed 24,601 eligibility re-determinations based on income or new hire information it received from the DOR. The Division uses DOR matches to identify discrepancies between the income and employment status reported by its members and DOR records. It follows up on match information with "targeted reviews" of member eligibility. Members are informed of the match information that was reported and given an opportunity to respond and verify accordingly.

Section 1931/Transitional Medical Assistance (TMA): Having completed all retroactive TMA outreach and processing requirements in SFY02, the Division maintained ongoing processes to establish and maintain TMA eligibility appropriately in SFY03.

Combined Application with Department of Transitional Assistance (DTA): The Division continues its interface with DTA's BEACON system to ensure that eligibility data is sent to the Division for all Temporary Assistance to Needy Families (TANF) applicants and processed for MassHealth eligibility.

Quality Control: Under the Demonstration, the Division uses an alternative Medicaid Eligibility Quality Control (MEQC) review process, comprised of a series of evaluations and informational studies related to MassHealth eligibility polices, procedures, and processes.

Two studies, the Validation of the Division's Classification of Expansion and Non-Expansion Eligibles (Systems Validation Study) and the IP Subsidy Validation Study (Insurance Partnership Study) happen annually. The first study verifies that the data in the system is consistent with information provided by the member, the integrity of the eligibility decision tree (in MA-21), and the benefits assigned to the member. The second is to assess whether members were correctly determined

eligible for a subsidy of employer-sponsored health insurance. Additionally, every six months MEQC conducts alternative studies on various aspects of eligibility for (1) the Division's "traditional" Medicaid population – including those over 65 and members needing long-term-care services and (2) the Division's Health Care Reform population - including members under 65 and non-institutionalized.

In SFY03 the Division conducted two alternative studies, which were as follows:

Study 1 – The Effect of Non-Response on Eligibility When Members Fail to Respond to Profile Reviews

The goal of this alternative study was to assess the profiling process of updating member eligibility status, and to evaluate the reasons why members don't respond to profile reviews. The Division sends members a profile review with the requirement to respond within 30 days. Failure to respond within the required time period results in the closing of the case. The study methodology was five-fold and involved an analysis of monthly case closings. The findings indicate that 27% of the non-responders overlooked returning the documents, which may indicate that members do not understand the importance of returning the profile.

Study 2 – Assessment of Regulatory Compliance with the Home Maintenance Needs Allowance Policy[*]

The goal of this study was to evaluate providers compliance with the Division's home maintenance needs allowance policy and determine appropriateness of interpretation. This policy stipulates that a home maintenance allowance deduction is available to members when a competent medical authority certifies that the patient's length of stay in the nursing home is six months or less. As such, this study evaluated: whether providers misinterpret the policy for members with a short life expectancy, whether members returned home within six months after the month of admission, and if the member remained in the nursing home did he/she continue to receive the home maintenance needs deduction. The study methodology evaluated single individuals without eligible dependents in the home that were later admitted to nursing home facilities for less than six months. The findings suggest that the Division should enhance education on the home maintenance needs policy and that standardized procedures are need.

Re-determination: Given the tremendous budget constraints of SFY03, the Division has stepped up its redetermination efforts to ensure that benefits are directed only to those who are eligible to receive them. The Division's automated eligibility review profiling system identifies members due for review and information is updated so that unnecessary redeterminations and closings are minimized. The Division has reduced from 60 days to 30 days the amount of

[*] This study is for the 65 and older institutionalized population that is not covered by the Demonstration.

time it allows for return of the redetermination information from the member and no longer includes self addressed, stamped envelops. The Division will continue to monitor the rate of redeterminations.

The Division continues to interface with managed care organizations and primary care physicians to inform them as their enrollees become due for redetermination so they can assist in retention efforts.

The Division has also increased its use of "targeted redeterminations." These are done in response to match information received from other agencies that indicate potential changes in a member's eligibility. The Division receives new hire and quarterly earnings information from DOR to prompt reviews if indicated.

Member Booklet Updates: The member booklet is updated whenever a change is made in eligibility rules or income standards. The member booklet was revised in April 2003. Among the revisions of note this year was information about new ways for members to authorize persons who may act on their behalf and with whom the Division may share information in light of the HIPAA Privacy rule.
(See Attachment 3 for the up-dated version of the member booklet)

HIV Expansion: As of the end of SFY03, there were approximately 995 persons enrolled in MassHealth due to the HIV expansion. Of those, 312 were enrolled in MassHealth CommonHealth and 683 were enrolled in MassHealth Family Assistance. The goal of the HIV expansion is to provide health care coverage to eligible individuals who are HIV positive, promoting access to early treatment of HIV disease, and to reduce or delay the progression of AIDS.

The Division and the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School are currently evaluating the implementation of the HIV Expansion. The evaluation focuses on two main areas: 1) member satisfaction with the services received and 2) the provision of access to quality care.

> *Next Steps:* An HIV Expansion member satisfaction survey has been developed and will be in the field in the fall of 2003. An assessment of access to care for this population is currently in progress. This assessment is based upon utilization and expenditure claims data and a report will be issued late 2003. As of September 1, 2003 eligibility was reduced from 200% FPL to 133% FPL. Approximately 125 members lost coverage.

V. Enrollment in Health Plans

Once the Division establishes eligibility for MassHealth, Health Benefit Advisors (HBAs) at the MassHealth Customer Service Center assist members in selecting a health plan based on the geographic location of their residence and their health care needs.

Enrollment in a health plan decreased by approximately 9% in the sixth year of the Demonstration, from 645,850 at the beginning of SFY03 to 592,034 at the end of SFY03. This was due in part to MassHealth Basic being partially eliminated on April 1, 2003. 79% of those participating in the MassHealth Demonstration receive health benefits from enrollment in a health plan. The other 21% have active Third Party Insurance, a 1% increase from FY 02. The health plan options include either the PCC Plan or a capitated MCO. On June 30, 2003 approximately 321,525 MassHealth members were enrolled in the PCC Plan, 270,509 were enrolled in the capitated MCOs, with additional enrollees in the process of selecting or being assigned to a health plan.

Standard, Family Assistance, and Basic coverage types had a 9% increase of enrollments into the MCO Program. Most of this increase occurred since we allowed doctors who had members enrolled with them through the PCC Plan convert their members to the MCO program of which the doctor is affiliated. Please note that members were notified prior to the conversion. Members could choose to remain with the doctor through the PCC Plan.

Standard Enrollment: As of June 30, 2003, 554,640 MassHealth Demonstration members eligible for Standard coverage were enrolled in a managed care plan. Of these, 45.75% were enrolled in a MCO, and 54.25% were enrolled in the PCC Plan.

Family Assistance Enrollment: There were 23,877 MassHealth Demonstration members eligible for Family Assistance coverage enrolled in managed care as of June 30, 2003. Of these, 48.85% were enrolled in a MCO and 51.15% enrolled in the PCC Plan.

Basic Enrollment: The enrollment of the long-term unemployed, eligible under the 1115 Demonstration waiver as MassHealth Basic members, continued in SFY03. Members eligible for Basic benefits must be enrolled in an MCO or PCC in order to receive services. As of June 30, 2003 there were 13,517 Basic members. Of these, 37.53% were enrolled in the MCO and 62.47% enrolled in the PCC Plan.

The following is a summary of the distribution of MassHealth Demonstration members in a MCO or the PCC Plan, by coverage type.

Table 3
Distribution of MassHealth Demonstration Members in Managed Care Plans
By Coverage Type SFY02 and SFY03 Comparison

Managed Care Plan	SFY02 Standard #	SFY02 Standard %	SFY02 Family Assistance #	SFY02 Family Assistance %	SFY02 Basic #	SFY02 Basic %	FY02 Plan Total #	FY02 Plan Total % /Total	SFY03 Standard #	SFY03 Standard %	SFY03 Family Assistance #	SFY03 Family Assistance %	SFY03 Basic #	SFY03 Basic %	SFY03 Plan Total #	SFY03 Plan Total % /Total
MCO Plan	208,600	37%	9,964	42%	19,333	38%	237,897	37%	253,771	46%	11,665	49%	5,073	38%	270,509	46%
PCC Plan	362,925	63%	13,563	58%	31,465	62%	407,953	63%	300,869	54%	12,212	51%	8,444	62%	321,525	54%

VI. Service Delivery

Behavioral Health Program and PCC Network Management Integration: In SFY02 the Division procured a combination PCC and BH network management contract. This contract continued in SFY03, key components included: increased integration of behavioral health and medical services, improved children's behavioral health services, services for special populations, and a focus on rehabilitation and recovery from mental illness and addiction. During SFY03, the Division and the contractor worked together to implement enhancements to the contract. These enhancements include:

- Continued provision of two additional levels of care coordination support for behavioral health (BH) providers and PCCs. These levels include care coordination and targeted outreach, and they are available to support PCC Plan and BH providers with delivering care to selected members;
- Implemented several conferences designed to help PCCs and BH providers better integrate medical and behavioral health (BH) care for members;
- Refinement of approaches and vehicles for educating PCCs about issues of concern to them, including BH-related issues;
- Asking PCCs at Regional Network Management (RNM) site visits about which BH providers they refer to, and then inviting providers not in the Partnership network to become part of the network;
- Member and provider newsletters that address issues related to both medical and BH care continue to be distributed. The provider newsletters go to both PCCs and Behavioral Health Providers

  Next Steps: In SFY04, there will be additional integration forums. In addition, a behavioral health measure will be added to the PCC Profile Report.

  The contract also contained performance incentives for SFY03, including one that specifically relates to behavioral health and medical care integration through working with pediatricians to encourage the routine use of a behavioral health screening tool.

Behavioral Health Program: Working closely with consumers, family members, providers, state agencies, and other stakeholders continued to be a priority for the Behavioral Health Program in SFY03. The following is a summary of the highlights from those activities.

Conference for Consumers on Rehabilitation and Recovery: In SFY03 the Partnership again hosted a statewide conference for consumers on rehabilitation and recovery from mental illness and addictions, which was attended by several

hundred individuals, including consumers, advocacy representatives, providers and program staff.

Division and DPH Relations: The Division and the Department of Public Health's Bureau of Substance Abuse, which is responsible for contracting with vendors for substance abuse services throughout the state, continue to work closely together. The Division, DPH, and the Partnership have created an interagency work group, to work on a number of initiatives. These include a major redesign of the acute treatment system (detoxification) and joint network management/ site visits to those programs, as well as an interagency effort to improve substance abuse services for adolescents. During SFY03, the collaboratively developed "Enhanced Acute Treatment Service" was implemented, providing improved access for dually diagnosed members.

Network Alerts: Network Alerts are policy directives that are sent to all network providers, and are issued by the Partnership. For example, in SFY03 a network alert was issued on the subject of the new Enhanced Acute Treatment Service. The goal of the alert is to educate the provider community and to promote proper referral and utilization of the new service.

System of Care Initiatives: The Division, in partnership with CMS and the Departments of Education (DOE), Mental Health (DMH), Social Services (DSS) and Youth Services (DYS), and several local School Departments, sponsors a pilot of comprehensive and coordinated medical, behavioral health and social services for MassHealth Managed Care-eligible children between the ages of three and eighteen who have serious emotional disturbance (SED). The Mental Health Services Program for Youth (MHSPY) pilot is operated by Neighborhood Health Plan, (NHP) through its contract with the Division. The program operated exclusively in the cities of Cambridge and Somerville from its inception in 1998 until the last quarter of SFY02 when it expanded to include the cities of Everett, Malden and Medford, increasing program capacity from 30 children at a time to 80. SFY2003 has seen a doubling of members and staff. The interagency partnership monitors the program for its quality of service and clinical outcomes. Currently, 67 children are enrolled, and 122 have been served since the inception of the program.

Also in SFY2002, the Division initiated an interagency effort to build on the knowledge gained from the MHSPY Pilot to create a similar model of comprehensive and coordinated care for children with SED. The programs are "sited" within a broader delivery system for public sector children's services. For this new model, Coordinated, Family-Focused Care (CFFC), the Division has contracted with MBHP to operate the program, collaboratively with DMH and DSS contracted community-based service providers.

CFFC, with a capacity of 250 children across five geographical service sites (Brockton, Fall River, Lawrence, Springfield and Worcester) became operational in the last quarter of SFY2003. The first children were enrolled in July and as of the end of September 56 children have been enrolled.

The service models for CFFC and MHSPY are similar but, with some significant differences. Both programs emphasize individualized and coordinated services, planned in partnership with the child's parents or guardians. Care management is provided by Master's level mental health clinicians who both facilitate resource identification and work directly with the child, family and collaterals. Both programs feature blended funds (federal, state and local, from the sponsoring agencies and local school departments) that are used to purchase individualized and comprehensive services and supports for children in the program. The MHSPY benefit fully integrates physical and behavioral health care with supportive services in the home, school or community, mentoring, recreation and skill development opportunities, collaborative care planning, care coordination, and care management. Children enrolled in CFFC have access to all of the same services and support as in MHSPY, but the program is organized by different entities. In CFFC, care planning, coordination and management are the primary mechanisms for integrating the delivery of care. Children enrolled in CFFC will receive physical health care through the PCC plan, behavioral health care through MBHP and the non-traditional and supportive services that round out the program through the contracted CFFC provider. During SFY03 five CFFC provider contracts were implemented.

Both programs are being evaluated with the assistance of the Center for Mental Health Services Research at the University of Massachusetts Medical School. The CFFC evaluation is being supported by grant funds received from the Center for Health Care Strategies (CHCS), in Lawrenceville, NJ. The results of these evaluations will inform the ongoing development of these programs as well as the larger service delivery system for children.

Depression and Primary Care: The Division, in collaboration with all five of its managed care contractors, applied for and received a Robert Wood Johnson Grant on Improving Treatment of Depression in Primary Care. The grant began in January 2002, with a planning phase to implement a care management approach to treating members with non-severe depressions within the primary care setting. By SFY03 a workgroup was formed to design the demonstration project. The design was approved and with the additional grant monies awarded. The demonstration project was implemented in multiple locations. A Policy Group was developed to monitor the project and address any barriers that are encountered.

PCC Capacity Report: The Division's provider capacity assessment continues to show that there is access statewide for members to choose PCCs. The Division's PCC Plan issues a Capacity Report every six months to identify potential access issues for PCC Plan members. The report provides a snapshot of MassHealth enrollment and contains information on the PCC Plan and unenrolled populations by service area. As of July 1, 2003, there were a total of 1,211 PCCs and 2,012 PCC sites, 1,688 of which are open sites. At that time there were a total of 1,537,876 slots, with 304,060 PCC Plan enrollees occupying slots, leaving a total of 1,233,816 slots available.

In SFY03 the PCC Plan Capacity Report continued to provide information on a service area basis (for 38 service areas) by provider type on the number of PCCs, number of PCC sites, and number of members. The report summarized for each service area the total capacity, slots remaining and number of sites, site specialties, and new sites. Information on PCC Plan members included total members, those unenrolled, and the age and gender breakdown of members.

Performance Improvement Services (PIMS) Vendor: In SFY03, The PIMS vendor continued to assist the Division in managing its network of PCCs, and in working with PCCs on quality improvement efforts. Under a single contract, The Partnership manages the PIMS vendor and behavioral health services. The Partnership was responsible during SFY03 for distributing PCC Profile Reports and other information that is central to the PCC Plan's quality improvement activities, and collaborating with PCCs in quality improvement (QI) activities.

The PIMS vendor was also responsible for managing the PCC telephone hotline, which is focused on answering provider questions. PCC Plan members with customer service concerns direct their calls to the Customer Service Center, operated under contract by MAXIMUS, the Member Service Unit's contracted vendor. In SFY03, the PIMS vendor administered a satisfaction survey to all PCCs, this survey asked about a variety of PCC Plan activities including PIMS and support materials. In SFY03, the Division identified and implemented activities to address those PCC concerns.

> *Next Steps:* In SFY04 the PIMS vendor will continue to work on enhancements to the Profile and Reminder Reports, and the Care Monitoring Registry (CMR). The CMR is a practice management, quality improvement tool that lists a PCC's members with diabetes. Included in the registry is demographic information as well as most recent date of PCC and non-PCC visit, HbA1c test, eye exam, LDL test, and microalbuminuria test. Also provided on the registry is space for the PCC to document lower extremity exam and flu vaccine. The CMR is a valuable tool to make PCCs aware of members in need of diabetes related tests with the ultimate goal of delaying or preventing complications of the

disease. Enhancements will include a behavioral health measure and a pharmacy measure.

Quality Forums: The PCC Plan holds quality forums for PCCs and their staff across the state. Meeting topics are based on the needs of the PCCs as expressed to the Regional Network Managers (RNMs) and may be repeated in different parts of the state (and counted as a unique cluster meeting). The SFY03 quality forum topics, dates and area of the state held were as follows:

12/4/02 – "How to reduce your No Show Rate: Policies and Interventions that Work!" in Worcester

11/19/02 -"Providing Optimal Care to members with serious Mental Illness in a Primary Care Setting" in Worcester

12/10/02 - "Asthma Update: Strategies to Achieve Success with Your Primary Care Clinician Plan Members" in Peabody

3/18/03 – "Patients Who Challenge Us: Approaches to Collaboration" in Brockton

3/27/03 – "Massachusetts Behavioral Health Partnership (MBHP) Primary Care Clinician (PCC) Plan Provider Integration Forum" in Holyoke

4/2/04 - "Massachusetts Behavioral Health Partnership (MBHP) Primary Care Clinician (PCC) Plan Provider Integration Forum" in Worcester

Next Steps: In SFY04, the PIMS vendor will continue to hold cluster meetings.

*PCC Profile Reports***:** In SFY03 the PCC Plan's Quality Management team continued to work closely with the PIMS vendor to support PCC quality improvement activities that resulted from information contained in PCC Profile Reports. (See Section VIII Quality Management for more detail on the Profile Reports.)

Semi-annually, a RNM visits each PCC practice receiving a Profile Report to review findings and discuss strategies toward improvement. (PCC Plan providers with more than 200 MassHealth PCC Plan members receive a Profile Report.) After reviewing the Profile Report, PCCs select one or two area(s) for quality improvement activities. The PCC then negotiates an action plan to address quality improvement activities in the identified area with the RNM, who then supports, in collaboration with the PCC Plan Quality Management Unit and other PCC Plan staff, the PCC in their efforts to implement quality management activity.

In FY03, the PIMS vendor trained two additional RNMs who will be responsible for visiting Behavioral Health providers with a Profile Report specific to members

with behavioral health service utilization. Both the BH-RNM and the PCC-RNMs attend an integrated monthly regional behavioral health meeting. Finally, the BH-RNM is available to consult with the PCC-RNM regarding behavioral health issues, and vice versa.

> *Next Steps:* In FY04, the PIMS vendor will continue to provide Reminder Reports and Care Monitoring Registry Reports to those PCCs no longer receiving the PCC Profile due to a recent decrease in PCC Plan enrollment, in order to enable those PCCs to continue to track care delivered to its PCC Plan members. In addition, there will be a new pharmacy measure in the profile report.

Provider Education Activity: The Division continued to pursue a vigorous provider education agenda, focusing on a broad range of the PCC Plan's components.

PCC Plan Quarterly: The *PCC Plan Quarterly* is a vehicle providing information to the PCC Plan's providers, and behavioral health providers. Under the new, integrated contract, the *Quarterly* is now sent to both PCCs and to the behavioral health (BH) network providers. This publication opens with a letter from the Medical Director, the PCC Plan Director, or the BH Programs Director that addresses a particular topic and how it relates to MassHealth and the providers. Following is a sampling of the topics included in the *Quarterly*.

Fall 02:

- Taunton Intensive Residential Treatment Program (IRTP)
- Letter from the Director: PCC Plan Enhancements
- HIPAA Compliance
- New Provider Directory Online
- Psychopharm Cooperation Between Patients and Doctors

Winter 03:

- Greater Lawrence Family Health Center Profile
- Letter from the Director: Integrating BH Care
- PCC- Clinical Advisory Committee (CAC)
- Targeted Outreach
- HIPAA Provider Privacy Notice
- Polypharmacy

Spring 03:

- Baystate Links School-Based Health Centers and PCCs
- Letter from the Director: Pharmacy Cost Savings
- Clinical Guidelines Now Linked to DMA web site
- Important HIPAA News
- HEDIS 2002 Results, Challenges with Diabetes

- Pharmacy Corner- Weight Gain: The downside of psychotropics

Summer 03:

- Berkshire Nurse Practitioner Gets to the Root of the Pain
- Letter from the Director: Results from fall 2002 survey on PCC Operations, provider relations, and PCC (PIMS)
- Important Numbers Updates
- Pediatric Practices Get Assistance with Behavioral Health Referrals
- PCC Plan Regulations and Contract Update
- Pharmacy Corner – Tracking High-Intensity Pharmacy Users

(See Attachment 4 for copies of the SFY03 editions)

Primary Care Clinician Plan Health Education Materials Catalog:
The PCC Plan, via the PIMS vendor, issued 2 volumes of the Catalog during SFY03. This catalog features materials developed by the PCC Plan, including a short description of the material and a picture of the material. Materials cover a range of topics to support the profiling activities including Maternal and Child Health, Emergency Department Utilization, Asthma, Breast and Cervical Cancer Screening and Diabetes. In addition, the catalog includes other supportive materials for PCCs, such as a Reminder Card and a PCC Plan Quick Reference Guide. The catalog also features a reference section that refers the PCC to other agencies that provide supportive materials on the same topics listed above. Finally, the catalog has information about how the materials can be ordered by the PCC, free of charge, through the PIMS Hotline.

The Regional Network Manager distributes an updated PCC Plan Catalog to all PCCs with 200 or more members during the semi-annual site visit.

Materials to be included in the catalog are reviewed and approved through a monthly meeting of the "Support Materials Review Committee" (SUMARC), a group composed of PCC Plan and PIMS vendor staff.

> *Next Steps*: In SFY04 the Plan will consider its ability to send a catalogue to all PCCs.

(See Attachment 5 for copy of the catalog)

Member education activity: The *Health Highlights Newsletter* now produced by the PIMS vendor, is a bilingual publication (English and Spanish) designed to provide news about the PCC Plan for PCC Plan members. The topics covered in these publications during SFY03 are listed below.

November 02:

- More children and Teens Now are at Risk for Diabetes

- Taking Medications? News About the MassHealth Drug List
- Feeling Blue after Your Baby is Born?
- Reminders: Can't Keep Your Doctor's Appointment?

March 03:

- See Your Doctor for Regular Checkups
- Teens and Drugs
- Lead Poisoning
- Talking to Your Doctor about Medications

(For copies of *Health Highlights* distributed in SFY03 see Attachment 6)

> *Next Steps:* Beginning in SFY04, the *Health Highlights* newsletter will be produced and distributed two times a year. Format and content will be reviewed and updated. Additionally, MAXIMUS will produce and distribute a PCC Plan Member Handbook.

PCC Plan Children with Special Health Care Needs: The PCC Plan has continued to work with other state agencies and providers to define a systematic approach to identify children with special health care needs within health care delivery systems. The goal of the "PCC Plan Children with Special Health Care Needs (CSHCN)" initiative is to propose a specific QI initiative to be used with PCCs that will lead to improved care for CSHCN enrolled with their practices. Activities will include compiling a catalog of known and related initiatives associated with identified barriers and best practice. The catalog will help inform data gathering and focus group initiatives already undertaken in the search for helpful interventions.

Staff from the PCC Plan participate in a workgroup, along with representatives of the MassHealth contracted MCO's and many of the other health plans throughout the Commonwealth, in an effort to identify methods of utilizing data to identify CSHCN's. Expected outcomes include exploring ways to target and measure QI efforts and the distribution of a newly developed resource manual for CSHCN's and their families.

> *Next Steps:* Staff will continue to participate in the Consortium for CSHCN's, an affiliate of NE SERVE. This is a group of providers, advocates, and consumers, partnering with state and private agencies that serve CSHCN's who come together to further the 2010 goals related to CSHCN's.

PCC Plan Care Management Programs:

In SFY03, the PCC Plan participated, along with the contracted MCOs and the Behavioral Health Program, in a Robert Wood Johnson funded grant project to improve the treatment of depression in primary care. The implementation phase

of this grant began in SFY03, and is being implemented at two sites, one in Holyoke and one in the Worcester area. The grant includes the provision of care management services delivered by a site-based care manager.

> *Next Steps:* In SFY04 the Division will implement care management services for MassHealth Essential members. Additionally, there will be an implementation of a PCC Plan site-based care management program using a nurse practitioner model for disabled, HIV, and AIDS members who are receiving PCC services at Brightwood Community Health Center in Springfield. Each of these programs is being administered by the Partnership.

Managed Care Organization (MCO) Program: The MCO Program covered a wide range of activities during SFY03 including the following highlights:

Continued Quality Improvement Activities: MCO Program staff continued to negotiate and evaluate MCO performance on QI goals; implement the Independent External Review of MCOs ("Clinical Topic Reviews" (CTR)); and participate in and lead the MCO-related activities for the Division's managed care quality measurement activities, such as the collection of Health Plan Employer Data and Information Set (HEDIS) information and using a modified Consumer Assessment of Health Plan Survey (CAHPS) to assess member satisfaction.

A pilot program for Children in Foster Care with Special Health Care Needs:
The Division and the Department of Social Services (DSS) co-sponsor a pilot program to enroll children who have special health care needs and are living in foster care at the time of initial program enrollment into Neighborhood Health Plan (NHP). The "Special Kids ♥ Special Care" Pilot Program which began enrollment in December 1999, provides a Nurse Practitioner to each enrolled child to provide and/or arrange for a full range of medical services to be delivered in the child's foster home or other appropriate settings when medically necessary. The Nurse Practitioner works with the child's DSS case manager, foster family, and primary-care physician to develop an individualized medical-care plan and arrange for the child to obtain necessary care and services. The DSS case manager remains responsible for the delivery of social services and other non-medical supports so the provision of a full range of medical and non-medical services is being addressed for the child.

During SFY03, the Division, DSS and NHP have continued to work together to administer each aspect of the pilot program including screening potential applicants, facilitating the application process, implementing the model of care delivery, and enrollment and disenrollment activities. As of the end of SFY03, the pilot program was actively serving 75 children, residing in the Boston/Metro, southeastern, northeastern, and central areas of the Commonwealth. Screening for potential enrollees is ongoing.

MCO Enrollment

The following table (Table 4) compares enrollment in the four MCO plans as of July 1, 2003 with enrollment on July 1, 2002. Pursuant to the state budget, the Division modified eligibility rules for MassHealth Basic, causing many Basic members to be disenrolled. This change impacted enrollment in the MCOs as well as the PCC Plan.

Table 4
Comparison of Enrollment in the MCO plans
July 1, 2002 and July 1, 2003

Health Plan	Enrollment as of July 1, 2003	Enrollment as of July 1, 2002	Percent Change from Previous Year
Neighborhood Health Plan*	93,915	112,718	-16.7%
BMC Health Net	112,119	74,524	+50.5%
Network Health	53,043	40,597	+30.7%
Fallon Community Health Plan	8,999	10,094	-10.9%

* NHP's enrollment fell during SFY03 in response to the Division's disenrollment of many of its disabled membership. This action was taken as a result of an intermediate sanction due to NHP's inability to meet the Division's solvency requirements and in order to ensure adequate access to care for the disabled members transferred to other health plans and for the members remaining enrolled in NHP.

Boston Medical Center HealthNet Plan and Network Health MCOs: In SFY03, the Division continued to work collaboratively with the BMC HealthNet Plan and Network Health. The Division and the plans worked toward increased volume of patients for these MCOs. In February, Network Health expanded into one new service area, Haverhill, which is located in the Northern region of the Commonwealth. During SFY03, BMC HealthNet Plan did not expand its service area. As a result of the service area expansions in both BMC HealthNet Plan and Network Health, and in conjunction with ongoing enrollment and outreach activities, membership continued to increase in the two plans during SFY03. As of July 1, 2003, BMCHP represents approximately 42% of MCO Program enrollment and Network Health represents 20% of MCO Program enrollment.

Quality of Care Activities: In SFY03, both BMC HealthNet Plan and Network Health continued to fully participate in all the ongoing quality improvement activities conducted by the Division's MCO Program. For example, both plans established individual MCO QIP activities,

participated in the workgroups around the Standard goals, and were evaluated in the MCO Program's semi-annual Contract Status Meetings.

Both of these MCOs also participated in the Division's HEDIS measurement activities, and the Independent External Quality Review (Clinical Topic Review) conducted with MCO and PCC Plan during the year.

CommonHealth:

MassHealth CommonHealth provides benefits to disabled adults, both non-working and working, and children who are not eligible for MassHealth Standard. There is no income limit for CommonHealth; however, non-working disabled adults are required to meet a one-time deductible before becoming eligible. CommonHealth allows members to earn an income and access employment. The success of the program is demonstrated by the 80% of CommonHealth adult members who have moved from other MassHealth categories into CommonHealth, with a higher incidence of other insurance and a lower average per member per month cost than other MassHealth programs.

Massachusetts Medicaid Infrastructure Grant (MMIG): The Division and the University of Massachusetts Medical School, Center for Health Policy and Research, are collaborating in a four-year Medicaid Infrastructure grant from the Center for Medicare and Medicaid Services awarded retroactively in SYF00. The overall goal of the grant is to establish better coordination among current health and non-health care related efforts of state and private agencies to promote the competitive employment of people with disabilities. The federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) authorized the national MIG programs. Massachusetts, based on the strength of the CommonHealth program, was one of two states to receive full MIG funding.
Grant activities include:

- A series of interventions aimed at supporting consumers with disabilities in achieving their employment goals, including maximizing awareness of and access to the existing Medicaid Buy-In program (CommonHealth) and providing additional services to those participating in the program. These efforts are coordinated through the CommonHealth Employment Connection (CHEC).

- A series of Monitoring and Evaluation (M&E) projects focusing on identifying specific employment barriers and mechanisms for overcoming barriers in order to improve programs and outcomes for consumers. These monitoring and evaluation projects focus on improving our understanding of the participants and services received through the CommonHealth program. The knowledge gained through the M&E projects will be used to maximize the effectiveness of the countries longest-standing 'buy-in' program and to provide useful information to

other states as they implement their programs. For example, at the direction of the Division the team undertook an evaluation of the CommonHealth Program's Premium Structure. The project evaluated the premium structure, by assessing the potential and likely impacts on public assistance program participation and employment, comparing the CommonHealth premium structure to other state and private programs, developing preliminary options for changes to the premium structure, and conducting a preliminary assessment of the likely fiscal and behavioral effects of the proposed options.

- Specific State-to-State Technical Assistance (SSTA) activities designed to provide and exchange information that assists in designing and implementing Medicaid Buy-in programs. Massachusetts convenes the Northeast Partnership for Health Systems Development (NEP) as a regional forum of MMIG representatives from Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Massachusetts also participates in two national technical assistance partnerships.

CommonHealth Premium Structure:
In March 2003 the Division implemented a new premium structure updating premiums for the first time since 1993. The new premium uses a narrower sliding scale based on a member's family income in relationship to the FPL. The effect, we anticipate, is likely to reduce potential work disincentives that might be associated with the previous premium structure which had fewer sliding scale steps and thus larger premium jumps when income increased to the next highest category. The new schedule is substantially more progressive than the previous schedule, that is, premiums increase at a faster rate with income.

Next Steps: In SFY04 the MMIG M&E projects will produce a second Premium Structure analysis and conduct at member satisfaction survey of CommonHealth and Standard members.

(See Attachment 7 for a copy of the New Premium Schedule)

Medical Security Plan (MSP): Individuals in Massachusetts who are unemployed, with income up to 400% of FPL, and who are receiving or are eligible to receive Unemployment Compensation Benefits may participate in the Medical Security Plan, offered through the Division of Employment and Training (DET). The DET contracts with Blue Cross/Blue Shield of Massachusetts to administer the program and provide utilization management services. The Commonwealth receives FFP under the Demonstration for this program.

The Medical Security Plan provides two different health insurance programs. Premium Assistance can provide partial reimbursement for premiums paid to

continue a health insurance plan whose coverage began while the individual receiving unemployment benefits was still employed (COBRA). The MSP member will be reimbursed at 75% of the actual premium paid (rounded to the nearest $1) up to a cap established for both family and individual plans. The maximum reimbursement is $523 for a family plan and $217 for an individual plan. The maximum reimbursement is set by regulation.

Direct Coverage is available to income-eligible individuals who have no access to health insurance benefits. They are provided with health care services, and are responsible for co-pays and deductibles. The applicant is enrolled in an indemnity plan and eligible to receive health insurance benefits through Blue Cross and Blue Shield of Massachusetts. If an applicant does have the option of continuing an existing health plan, they may qualify for a hardship waiver for participation in Direct Coverage. Premiums for the Direct Coverage option of the Medical Security Program are $20 per week for individual coverage and $30 per week for family coverage. The premiums are automatically deducted by the Division of Employment & Training from individuals' weekly unemployment benefit checks.

For the year ending August 31, 2003, the monthly average number of primary enrollees (i.e. the person collecting unemployment insurance) was 11,024 with 9,451 dependents enrolled. Forty-five percent (45%) of the primary enrollees elected the Direct Coverage option and fifty-five percent (55%) were enrolled in Premium Assistance.

Compliance with Balanced Budget Act: During SFY03, the Division worked closely with staff from the Regional and Central Offices of the Centers for Medicare/Medicaid Services (CMS) to bring its managed care programs into compliance with the new Medicaid Managed Care Regulations promulgated as a result of the Balanced Budget Act of 1997. These regulations impacted the PCC Plan, the BH Program, and the MCO Program. Division and CMS staff worked closely to determine which portions of its current programs were "grandfathered" under its pre-existing 1115 Demonstration Waiver extension and which portions would need to be modified to come into compliance by the deadline of August 13, 2003. These changes impacted both programmatic and financial components of the program. The necessary contract amendments and regulation changes were implemented by August 13, 2003.

VII. Family Assistance, Premium Assistance and the Insurance Partnership

The MassHealth Family Assistance Premium Assistance (FA) and IP Programs are designed to make employer-sponsored insurance (ESI) affordable to low-income workers and to encourage and assist small employers in offering health insurance.

- The FA offers subsidies, on behalf of eligible MassHealth members (children with incomes between 150-200% of FPL and adults working for participating small businesses with incomes at or below 200% of the FPL), to help low-wage workers pay their share of ESI;

- The IP offers subsidies to participating small businesses to help pay for health insurance premiums for low-wage workers and to low-income, self-employed individuals.

The Division requires that the ESI meet the following minimum requirements:

1) The employer must contribute at least 50% to the cost of the health insurance premium;
2) The offered plan must meet the Basic Benefit Level; and
3) Providing premium assistance must be cost-effective for the Commonwealth.

Key Objectives: Several key objectives have continued to guide development and implementation of the FA and IP programs, including:

- Preservation and promotion of private employer-sponsored health insurance dollars to avoid commercial sector crowd-out;

- Provision of FA and IP premium assistance payments to help low-income families, individuals working for small employers, and self-employed individuals obtain and maintain ESI which would otherwise prove cost-prohibitive;

- Provision of IP employer incentive subsidies to assist in preventing long term decline in the private insurance market by encouraging small employers to offer health insurance coverage and by acting as a “cushion” for small employers who offer coverage to their employees;

- Provision of premium assistance enables the purchase of family coverage which allows not only the child(ren) but also their parent(s) to obtain coverage.

- Continued utilization and interface with systems, mechanisms, and structures in the private insurance market through contracts with IP vendors including Billing and Enrollment Intermediaries (BEI's) and Employee Benefits Resource (EBR), to work specifically with small business employers.

Administration of Family Assistance Premium Assistance and the Insurance Partnership programs: There are two administrative routes for those eligible for FA and who have access to ESI to obtain premium assistance through MassHealth.

The first route to obtain premium assistance is through the IP for MassHealth eligibles who have access to ESI through a small employer. Two separate operational mechanisms support the IP, with usage defined by the type of arrangement the employer has in place.

BEIs serve employers on a range of insurance coverage needs, including the IP. The BEIs conduct enrollment and provide continuing administrative support for very small firms. The BEIs collect information necessary to determine eligibility for the employer, and verify continuing insurance coverage. In addition, BEIs forward employee applications to MassHealth for processing. Incentive payments and premium assistance payments are deducted from an employer's overall insurance bill. Employers are required to adjust the amount withheld for health insurance from the employee's paycheck to account for the premium assistance payment.

Employee Benefits Resource (EBR) administers the subsidies for employers and employees in firms with up to 50 employees, including very small firms and self-employed people who do not buy coverage through BEIs. EBR reviews employer applications, conducts employer enrollment and disenrollment, forwards employee applications to MassHealth, sends subsidy payments to participating employers and verifies continuing insurance coverage. Employers are required to adjust the amount withheld for health insurance from the employee's paycheck to account for the premium assistance payment.

The second route to obtain premium assistance is targeted toward families with income-eligible children who have access to ESI but who do not work for companies qualifying for participation in the IP, primarily because of the size of the employer (over 50 employees). Children are determined eligible to receive premium assistance as a result of an investigative process managed by the Division's contractor, Public Consulting Group (PCG). Among the information PCG verifies are the applicant's employment status and eligibility for insurance

and to ensure that the ESI meets Division requirements. For families who report to the Division that they are currently uninsured, their children are provided direct MassHealth coverage for up to 60 days while PCG conducts its investigation. For both the FA and the IP, if the insurance meets the basic benefit level and the child was previously uninsured, the child is considered S-CHIP eligible.

Current Statistics: As of June 2003, 7,379 policies were purchased through the FA and IP programs. Approximately 53% of the policies purchased were family policies, 41% were purchased individual policies, and 6% were either couple or dual policies. In total, these policies covered 18,646 lives, almost 40% of which are children.

As of June 2003, 4,809 small employers were participating in the IP program, nearly 69% of those participating were self-employed individuals and nearly 87% employed five or fewer workers. Nearly 48% of those who are self-employed were purchasing a dual, couple, or family policy. As shown below, employer enrollment in the IP continued to grow in SFY03.

Table 5
Growth of Number of Employers Participating in the Insurance Partnership from June 2002 to June 2003

Employer Size (# of Full-Time Employees)	June 2002	June 2003	% Increase From June 2002
1(Self-Employed)	2,928	3,316	13%
2 to 5	799	872	9%
6 to 9	143	166	16%
10 to 50	450	451	.2%

(See Chart 3 “Policies Purchased by Type of Policy” and Chart 4 for “Lives Covered under Family Assistance Premium Assistance 2003”)

SFY03 Initiatives and Activities: In addition to continuing marketing and outreach activities, which proved successful for SFY02, the Division increased support for FA and IP during SFY03 by enhancing existing activities and implementing new primary and secondary initiatives. On behalf of the Division, EBR conducted an IP promotional campaign consisting of three sequenced mailings to approximately 252,000 small businesses, non-profit organizations and government agencies. In areas with high concentrations of potentially eligible employees, targeted “direct-response” mailings were conducted. The mailings included an employer/employee eligibility worksheet that the recipient could fill out to verify eligibility, and fax or mail back for additional information and applications. Insurance brokers and agents received several mailings promoting IP and encouraging enrollment in a two-credit continuing education IP review

sanctioned by the Division of Insurance. Hospitals in areas of high-uninsured populations were targeted for enrollment training and brochure racks were distributed.

A new system was implemented for tracking potential members, rating the company based upon their prospect for entrance into the program. The system automatically creates follow-up activities for marketing staff.

Throughout SFY03, many regularly scheduled and as requested meetings were held state-wide with business associations, state agencies, non-profit, human and social service organizations and advocacy groups to provide ongoing IP and FA education, information, training, speakers and support. All outreach and marketing initiatives promoted and encouraged the use of IP's toll-free 800 telephone number and website resulting in increased utilization of each resource.

During SFY03, the Division undertook an evaluation of the Family Assistance Premium Assistance and Insurance Partnership programs.

(The evaluation report and recommendations are contained in Attachment 8)

VIII. Quality Management

The Division employs a variety of methods to monitor the quality of its health plans and member satisfaction. For example, the Division incorporates specific quality standards into its MCO contracts. The Division also applies HEDIS measures to all managed care plans, including the PCC Plan, to assess clinical quality (sometimes these are assessments of process or assessments of utilization). The Division also conducts an annual Independent External Quality Review, called the Clinical Topic Review (CTR), in a focused clinical area. Whereas previously this study was only conducted with the MCOs, during SFY03, the Division began also including the PCC Plan in this study. Quality management endeavors that are specific to the PCC Plan, its behavioral health vendor, and the capitated MCOs, are summarized below, followed by a specific discussion of HEDIS measures and the CTR.

PCC Plan: The quality management activities for the PCC Plan are derived from goals developed by the Division and by the PCC Plan. Relevant data from Plan operations, such as aggregate PCC data, Profile Reports, HEDIS measures, and the MassHealth Member Survey is used to guide the development of Plan goals. Additionally, in SFY03, the PCC Plan participated in the MCO Independent External Quality Review,CTR, and will consider these results in addition to the aforementioned data to inform the development of Plan goals.

The PCC Plan addresses quality issues in three ways. One is through QIPs that involve both internal and external stakeholders as a team with an identified goal to improve the rates/standards of a particular service. The second is through various ongoing educational activities that usually are developed as a part of a QIP. The final method is through PCC Profiling and working with the PCCs to develop and implement action plans.

PCC Profiling and Action Plans: PCC's select an area(s) for quality improvement from the PCC Profile Report. PCC Profile Reports for PCCs with over 200 PCC Plan members are important tools in helping PCCs assess their own performance, and, in conjunction with the RNM, identify their own areas for improvement and intervention strategies. The PCC then collaborates with the RNM to develop and implement an action plan to address quality improvement activities in identified areas.

The following is a description of activities and materials developed as part of a QIP or as educational activities by the PCC Plan during SFY03 to provide information and education to PCCs related to the PCC Plan's quality improvement activities.

Asthma

The PCC Plan participated in the CTR for the first time in 2002. One of the topics selected for review was children with asthma. The Review highlighted potential areas for improvement in the documentation of care including: level of asthma severity, education regarding prevention of Emergency Department (ED) visits or hospitalizations, referral completion to specialists and acknowledgement that the referral was received. The PCC Plan continues to educate PCCs regarding these issues by endorsement of the National Heart, Lung, and Blood Institute's (NHLBI), Guidelines for the Diagnosis and Management of Asthma.

> *Next steps:* Asthma QI activities will focus on including Asthma in the PCC Plan Care Monitoring Registry (CMR). The CMR is a new practice management, quality improvement tool that currently identifies members with diabetes. In response to PCC requests, CMR 2 will list members with persistent asthma as well as demographic information, dates of visits to the PCC and non-PCC, ED and hospital admissions, and the number and date of controller and reliever medications dispensed. PCCs will be encouraged to identify members in need of asthma related care.

Emergency Department (ED): During SFY03, the following materials continued to be distributed:

- *Member Wallet Card:* The member wallet card is used to educate members about accessing primary care, urgent care, and emergency care. The card gives examples of each type of care and appropriate steps on how to obtain each kind of care. Health care providers are encouraged to send a card after a member has made an ED visit. This is an activity that began in SFY99 and is ongoing. The wallet cards are available in English and Spanish, and can be ordered through the Health Education Materials catalog. There were 4,092 English wallet cards ordered in SFY03, and 1,656 Spanish wallet cards ordered in SFY03.

- *Member Fact Sheets:* These are double-sided fact sheets, English on one side and Spanish on the other, which gives the members helpful information on how to access health care. One is titled *Care Whenever You Need It,* which gives the member information on what to do if they become ill. There were 5,280 *Care Whenever You Need It* fact sheets distributed in SFY03. The second fact sheet is titled *Before You Go to the Emergency Room* and gives members information on how to decide what kind of care is needed and who to contact. There were 7,572 *Before You Go to the Emergency Room* fact sheets distributed in SFY03.

Well-Child–Care Visits: The following support materials have been developed and are distributed through the PCC Plan catalog. These materials support the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for well-child care.

- *Help Your Child Grow Up Healthy:* This publication reminds PCC Plan members to take their newborns and children, even if healthy, to a doctor for checkups. The brochure stresses the importance of children having well-child care visits and also discusses immunizations and how to keep track of their child's health records. Hotline numbers are listed for members to access additional information or to ask for help in accessing services. This brochure is published in English, Spanish, and Portuguese, and can be can ordered by PCCs.

- *Choosing a Doctor or Nurse for Your Child:* This publication is available to all PCCs and obstetric providers with the goal of helping pregnant women to choose a primary care provider for their child before delivery in order to ensure immediate and early access to well-child care services and avoid unnecessary emergency department visits.

- *Well-Child-Care Visit Schedule Card:* This postcard size well-child care visit schedule reminds parents when their child is due for a check-up. Also included is a place for the name of the child's health care provider and the provider's phone number. The card is printed in Spanish on one side and English on the other. This publication has been well received by providers as indicated by the large numbers ordered.

- *The Facts-Well-Child-Care Screening and Diagnosis Services:* This fact sheet gives PCCs a brief overview of EPSDT services. The topics covered include: referring out screening services, billing, further diagnosis and treatment services, determining medical necessity, MassHealth coverage types, support services, and how to get additional information. This publication is also a useful tool for providing an EPSDT overview and training to any other people who assist in caring for children on MassHealth, such as DSS staff.

- *EPSDT Billing Guidelines:* This booklet presents billing scenarios and accompanying questions and answers to provide some guidance on how to bill for EPSDT services provided in accordance with the EPSDT Schedule. The booklet was prepared by the Division with the help of the MCAAP.

- *Quick Guide to Early Childhood Dental Care:* This poster can be used by pediatric PCC's as a guide to educate parents about dental care for children 0-3 years old. It includes risk factors for early childhood caries, child/infant oral exam technique tips, as well as helpful facts about fluoride.

- *MHQP Pediatric Preventive Care Guidelines 2003 Poster:* Compiled by Massachusetts Health Quality Partners (MHQP) a broad-based coalition of health plans, health-care providers, purchasers, and government and academic representatives working together to promote improvement in the quality of health-care services across the Commonwealth. The recommendations reflect the requirements of the Division's EPSDT Medical Protocol and Periodicity Schedule. In May of 2003, this poster was mailed to all providers that care for children in Massachusetts. The poster will continue to be available to PCCs upon request. There is an electronic link on the Division's website to the MHQP website for quick and easy access for providers. Training was provided for the PCC Plan RNM's on the content and strategies for promoting the Guidelines.

  Next steps: 1) A summary of the Guidelines will be printed and made available to providers for use as a desk-top reference. 2) Based upon a needs assessment done with our PCC providers, a well child care documentation form will be adapted to comply with Massachusetts EPSDT requirements and made available for distribution to providers by the RNMs and through the catalog.

- *Improving relationships between PCCs and School Based Health Centers (SBHCs)*: In SFY03, PCC Plan staff continued to strategize with the DPH SBHC program on how to improve communications between PCC's and SBHC's. The goal was to facilitate better exchange of information, to improve the quality of care for shared patients, and for PCCs to utilize SBHC's as an outreach point to link adolescents to primary health care. In October, the PCC Plan and DPH SBHC Unit did a joint presentation at Baystate Medical Center Pediatric Grand Rounds meeting on how PCCs can benefit from a collaborative relationship with SBHCs. In addition, PCC Plan staff continued to refine support materials to achieve the goal of improved communication; however, due to budget cuts the to the SBHC program, the material development and distribution was put on hold. The overall project will be revisited in SFY04 if funding is available for the SBHCs through DPH.

- *Women, Infants and Children (WIC) Nutrition Program Initiative*: A formal agreement between the Division and the WIC Program has been developed to facilitate an exchange of data that will enhance the outreach to MassHealth members who are also eligible for WIC benefits. The Division distributes WIC outreach materials to all applicants for MassHealth and includes information about WIC in the EPSDT notices sent to families of MassHealth children. WIC distributes MassHealth enrollment materials in clinics to ensure that all children have an opportunity to access insurance.

Next steps: Data match will begin in SFY04, the Division will share data about MassHealth members who have indicted that they are pregnant and infants and children under 4.5 years, WIC will match their enrollment files and outreach to those potentially eligible women and children.

- *Department of Social Services (DSS) Collaboration*: Efforts are underway to improve the communication links between the staff at DSS, foster care providers and the Division. Specifically these efforts are aimed at assuring that training materials reflect current practices and policies of the Division, that DSS staff has established avenues of communication with all departments within the Division, and that children in foster care are receiving health care in the most appropriate manner.

  A data analysis was done and used as the basis for the generation of a report produced collaboratively with DSS. This document reports on the health care access, demographics, quality indicators and utilization for children in DSS care and custody. PCC Plan quality indicators were used as comparison when available. This report, in conjunction with two companion reports that will be released in SFY04, will inform the quality improvement efforts that are being undertaken by the two agencies.

- *MassHealth Adolescent Anticipatory Guidance Public Awareness Campaign (MAAGPAC)*: The PCC Plan, MCO's, the DPH, and the UMass Access Project joined together to increase the rate at which adolescents have an annual well-child care visit and thereby increase opportunities that providers have to deliver age appropriate anticipatory guidance.

  A public awareness campaign was initiated, consisting of public-transit advertising, posters which are widely displayed indoors and outdoors throughout Massachusetts' communities, and postcards developed by and for teens 14-16. Additionally, a public service announcement was developed and aired on the Spanish language channel on cable TV.

  Next steps: A toolkit will be mailed to 200 Community agencies that serve teens. The toolkit will consist of posters and postcards (English and Spanish), a list of frequently asked questions written from the teen's perspective that offer information on enrollment in MassHealth and managed care options, choosing a provider, confidentiality, and other issues important to teens, statistics developed as a call to action, and web and telephone resources.

EI (Early Intervention) Partnerships: The Division and DPH collaborated with multiple community partners to redefine the goal and operational aspects of this

community based perinatal program, which is partially funded by an ISA from the Division. This collaboration resulted in a model of care that will be more targeted, cost effective and measurable and be directly linked to EI services.

> *Next steps:* The model will be evaluated on evidence-based standards of care.

Lead Screening: The Division and DPH collaborated on an article published in Health Highlights, the member newsletter, to educate parents on the environmental hazards contributing to lead poisoning and the methods and available resources to ameliorate those hazards.

An Interagency service agreement (ISA) has been developed to coordinate activities and facilitate a data exchange between the DPH Childhood Lead Poisoning Prevention Program (CLPPP) and DMA in order to obtain accurate data on blood lead screening rates and levels for children enrolled in MassHealth for reporting purposes, and to assist both agencies in developing quality improvement efforts to ensure that children are getting adequate screening.

> *Next steps:* In SFY04 the data will be exchanged for SFY03 and FFY03. This will become an on-going exchange and the data will inform quality improvement efforts between the PCC Plan, MCO's and the CLPPP.

Immunization Activities:

Information Sharing and Collaboration with the DPH Massachusetts Immunization Program (MIP): The MIP administers a program that visits provider offices to perform chart reviews of a sample of the practice's two-year olds to determine if the practice is successful in ensuring that its two-year olds are fully immunized. The MIP gives the provider a detailed report (immunization assessment report) outlining the areas that need improvement and offers evidence-based strategies for improving and maintaining immunization levels. The Division and the MIP entered into an agreement that would allow the MIP to ask providers who receive an MIP Immunization Assessment to consent to the MIP sharing the provider's Immunization Assessment report with the Division. The PCC Plan and MCO staff will be able to use the data and reports to initiate new and targeted immunization quality improvement activities. Immunization reports are received and shared with the PCC Plan RNMs to facilitate the establishment of a quality improvement action plans at the PCC site based on the deficiencies identified in the assessment report. There has been the development of a two minute health message in Spanish on Univision called "Missed Opportunities" which provides information on the importance of immunizations and when it is safe to vaccinate. The goal of the message was to decrease the incidence of children deferring vaccination when it was safe for them to be given the immunization.

Next steps: The PCC Plan will nominate practices to the MIP that are in need of an immunization assessment. The MIP staff has agreed to work with the PCC Plan to prioritize these sites for assessments in the upcoming assessment cycle. Both the PCC Plan and MIP staff will continuously evaluate ways to improve the information sharing process. They plan to continue with planning sessions to improve practice rates.

Participation in Government Performance Results Act (GPRA) Immunization Activity: GPRA is a CMS-sponsored multi-year initiative to improve immunization rates for two year olds. In September 1999, the Division submitted baseline information derived from its HEDIS 1998 Report on the immunization status of MassHealth two-year-olds enrolled in the PCC Plan and the Division's contracted MCOs. In January 2001, the Division submitted to CMS its interim measurement based on its HEDIS 2000 results. In SFY02, the Division continued its quality improvement activities in support of the Division achieving its final GPRA goal of 80% of MassHealth-enrolled two-year olds being fully immunized. The Division submitted its final measurement to CMS in SFY03. The Division has completed its third and final year with formal participation of the report. The Division will continue to participate in the project as a resource for the other states still collecting data.

MHQP Endorsement of the MIP Childhood Immunization Guidelines: In SFY03, MHQP endorsed the DPH immunization guidelines for the fourth year in a row. MHQP and the MIP will again distribute the immunization guidelines to all providers in the Commonwealth who care for children. The Division is a member of MHQP.

Development of a Publication Discussing Missed Opportunities in childhood immunization with data from the MIP Program and the CTR Report: In SFY02, the PCC Plan and the Division's MCOs developed a publication for providers titled "Best Practices to Prevent Missed Opportunities in Childhood Immunization" which outlines activities providers can undertake to address missed opportunities in childhood immunizations. Both the MIP, through its Immunization Assessments, and CHPR, through its CTR for the MCO Program, had identified similar areas for improvement. These publications offer supporting data and deliver a universal message for MassHealth providers about the root causes of missed opportunities in vaccine administration and strategies to address these issues.

This publication was included in the MHQP/MIP mailing of the CY2002 (SFY03) MIP Immunization Guidelines. In addition, this publication continues to be included in the PCC Plan Health Education Materials catalog.

Women's Cancer Screening: During SFY03, the following materials continued to be distributed: A revised and updated brochure in English and Spanish for

members was developed to educate members on the importance of the Pap smear. Pamphlets on Mammograms, reminder cards for scheduled health visits, and a video based self study packet for clinicians on self breast exam and mammogram findings are available and continue to be distributed.
Performance reports are provided by the PCC Plan to providers that identify members in need of woman's cancer screening. RNM's review the identified members in need of screening with the providers and action plans are devised to obtain screening for those members in need. Regional Managers are also provided with updates and training on the guidelines for woman's cancer screening.

> *Next Steps:* The Division will continue to support RNMs in action plans to increase rates of women's cancer screening.

MHQP Adult Preventative Care Guidelines: During SFY03 the Division participated in revision, endorsement and production of adult preventative care guidelines. These guidelines were placed on the Division website.

Diabetes:

Diabetes care for PCC Plan members was identified as an area for improvement in 1999. Since then multiple initiatives have been undertaken. HEDIS 2002 Comprehensive Diabetes Care Measure results indicated improvements in all measures except HbA1c control. SFY03 initiatives include:

CMR Development: The CMR is a practice management, quality improvement tool that lists a PCC's members with diabetes. Included in the registry is demographic information as well as most recent date of PCC and non-PCC visit, HbA1c test, eye exam, LDL test, and microalbuminuria test. Also provided on the registry is space for the PCC to document lower extremity exam and flu vaccine. The CMR is a valuable tool to make PCCs aware of members in need of diabetes related tests with the ultimate goal of delaying or preventing complications of the disease.

Diabetes Reminder Card: A Diabetes Reminder Card was developed as a compliment to the CMR. The Card provides a checklist of diabetes related tests/exams. As the PCC reviews the CMR and identifies a member in need of a test/exam, the card is completed and mailed to the member as a reminder to make an appointment with the PCC or visit the appropriate clinician for the service. The Cards are available to PCCs via the PCC Plan Health Education Materials Catalogue.

Massachusetts Guidelines for Diabetes Care (2003): The Diabetes Prevention and Control Program of the DPH collaborated with the PCC Plan as well as other

health plans to update the 2001 Guidelines to include revised clinical recommendations.

> *Next steps*: In SFY04, the Division will promote and distribute the revised Guidelines to PCCs.

Flow Sheet for Diabetes Care: This tool is a medical record flow sheet intended for documentation of diabetes care provided in an office setting. The Flow Sheet was developed as part of the Massachusetts Guidelines. In the past year the PCC Plan has promoted the Flow Sheet with PCCs to improve documentation of diabetes care.

> *Next Steps:* The PCC Plan will participate in the HEDIS 2004 Comprehensive Diabetes Care Measure by collecting data, analyzing results and identifying possible areas for improvement in diabetes care.

Perinatal Care Quality Improvement Project (PQIP): The PQIP is structured to implement activities in a coordinated manner across both the PCC Plan and the MCO Program. Accordingly sub goals have been identified, with specific activities undertaken in their support.

Recipe for a Healthy Baby: A major goal for the Division has been to increase the percentage of women who receive timely and adequate perinatal care. The PQIP developed a tri-fold colorful guide featuring four key messages. The first was to get early prenatal care and that proper nutrition was vital to making sure you have a healthy baby. The second message was to take a vitamin with folic acid every day. The third was not to smoke, drink alcohol, or use drugs during pregnancy. The fourth message told them to protect themselves and their children from domestic violence. The pamphlet includes help-line numbers allowing women to seek more information. An English and Spanish version of the brochure is currently available. In SFY03, the Division continued to distribute this material, updated to reflect current phone numbers, to all pregnant women or members with a pregnant family member applying for MassHealth.

MHQP Perinatal Guidelines and Risk Assessment Form: In SFY03, MHQP mailed the perinatal care guidelines, and associated Risk Assessment form to all physicians, Certified Nurse Midwives and Nurse Practitioners statewide. MassHealth is supporting the distribution and endorsing the use of the Guidelines and Risk Assessment Form and performed two mailings in SFY03. One mailing included a Tool Kit (components listed below under Member and Provider Education Activities), which was mailed to all MassHealth Obstetric Care Providers statewide. The second mailing included the Guidelines, the Risk Assessment Form and a referral resource list.

> *Next Steps*: Update the Guidelines as needed.

Member and Provider Education Activities: In SFY03, the PQIP continues with distribution of the following member education materials related to the content and frequency of perinatal care for members.

- A postpartum reminder card for use by providers to remind women to make or keep their postpartum visit is available through the PCC Plan Health Education Materials catalog and is included in the Perinatal Tool Kit mentioned above.

- A brochure "After Your Baby is Born: YOUR POSTPARTUM VISIT" was developed and distributed to full term pregnant women and new moms to encourage postpartum women to get a check-up after delivery. This brochure is available in the PCC Plan Catalogue and was included in the Perinatal Tool Kit mailing.

- A brochure, "Choosing a Doctor or Nurse for Your Child" encourages pregnant women or new moms to choose a doctor or nurse for their baby. This is included in the PCC Plan Catalogue and was included in the Tool Kit mailing

- A flyer entitled "Moms Are Special Too" continues to be enclosed in the WIC mailings that go to every woman in the Commonwealth who has a live birth. This flyer encourages women to go for their 4-6 week postpartum visit. This flyer is mailed every month.

- Also during SFY03, an educational video was developed and aired on Univision New England, the largest Latino television network in the United States. The video which was in Spanish, focused on educating women about the purpose of and importance of perinatal and post partum care. A 20 page booklet covering key points in pre-conception through postpartum care was created in collaboration with the DPH. This booklet was titled "Guide to a Healthy Pregnancy".

  Next Steps: Sample of ten booklets will be distributed to MassHealth obstetrics providers. The booklet will also be available through the PCC catalog. A distribution plan to include mailing the booklet to newly enrolled members in the PCC plan is being formulated. Plans are also being made for the booklet to be available in community health centers and translated into Spanish.

  The PQIP has a number of activities underway in SFY04, including:

- To produce a public service announcement from the educational video to be aired on Univision as a two minute health messages or a 30 second Public Service Announcement.

- PCC Plan Staff will attend a WIC regional meeting to educate WIC staff on the importance of women going for their postpartum visits. WIC has offered to encourage women to schedule these appointments when they are at the WIC office.

- An article was submitted and published in the MCAAP's newsletter, the Forum, educating Pediatricians of the importance the postpartum visit and soliciting pediatrician's assistance in reminding women to schedule the appointment when they bring their children in for well or sick visits.

  Next Steps: To continue to publish articles in both the provider newsletter and the member publication on topics relating to Maternal Child Health.

- PQIP officially partnered with the March of Dimes on their campaign to reduce premature births in Massachusetts. Statistics support that the rate of premature births continues to increase in Massachusetts. In accordance with the goals of PQIP educating members on signs and symptoms of premature birth should help members seek timely care and decrease poor outcomes.

Department of Mental Health affiliated PCC Plan members:

Provider profiling developments led to the inclusion of special reporting of the rates at which DMH affiliated members of the PCC Plan have received a number of basic primary care services. Additionally,"primary" behavioral health care providers were identified and were provided with their clients' medical service profile. With the support and encouragement of the RNMs, clinicians were to utilize this information to remind and advise their clients/patients of the importance of receiving routine and preventive primary care.

PCC Profile Reports: As previously noted, the Division uses its PCC Profile Reports to help PCCs identify areas for improvement, and to identify related improvement interventions. PCC Profile reports are provided for each PCC practice serving more than 200 PCC Plan members. These PCCs serve 86% of the PCC Plan population. An RNM visits each PCC practice receiving a PCC Profile Report to review findings and develop quality improvement activities. The PCC Profile Reports are supported by information developed and/or compiled by the PCC Plan Quality Management staff.

In SFY03, the Profile Report Improvement Meeting work group met biweekly to discuss ongoing quality improvement for the report. Enhancements made to the

PCC Profile Report included the introduction of benchmarks based on a new methodology, Achievable Benchmarks of Care, or the 90th percentile rate, the addition of 2-4data points to trend PCC performance, and the following rates added to the diabetes measure: % of members with annual LDL testing, annual eye exam, and annual screening for microalbuminuria.

The Reminder Report continued to list members overdue for well child care visits, cervical cancer screening, and breast cancer screening, as well as asthma medications dispensed to members with persistent asthma. An enhancement included a listing of members with two or more ED visits within the previous six months.

Member addresses and phone numbers were added to assist PCCs with outreach efforts, and information on members who appear on consecutive reports are shaded, highlighting those most in need of a particular service. The asthma data was moved to a new report, the CMR.

A Care Monitoring Registry (CMR) was introduced in PCC Profile Report 15 to support PCCs' management of members with chronic disease. The first CMR included detailed information on members with diabetes and summarized services members either received or were in need of, in accordance with the Massachusetts Guidelines for Adult Diabetes Care. Detailed data on members with asthma was added in PCC Profile Report 16.

PCC's select an area(s) for quality improvement from the PCC Profile Report and collaborate with the RNMs on developing Action Plans that address the planned quality improvement activities. As of June 30, 2003, PCCs had initiated:

- 244 Action Plans related to Well Child Care
- 139 Action Plans related to Asthma
- 167 Action Plans related to Emergency Department Utilization,
- 178 Action Plans related to Cervical Cancer Screening,
- 151 Action Plans related to Breast Cancer Screening,
- 102 Action Plans related to Diabetes,
- 21 Action Plans related to PCC/BH integration.

Next Steps: The PCC Profile Report Version 16 will include a new pharmacy measure, while the CMR 2 will include information on all members with asthma, and medication summaries on members dispensed eight or more medications in the previous quarter.

PCC Behavioral Health: As a part of ongoing quality management, the Division regularly receives data from the Partnership measuring continuing care rates, access to after care services, re-admissions, claims processing times, telephone answering information and a broad array of service utilization details.

Several special projects were undertaken during SFY03, including:

- The second phase of "Behavioral Health Screening in Primary Care Pediatric Practices." Phase 2 included improving the behavioral health referral toolkit and the efficiency of the referral process, as well as expanding the number of participating pediatric practices from 10 practices in SFY02, to 50 practices in SFY03.

- The development of "Coordinating Discharge and Community Aftercare Planning" which included focused efforts to achieve a reduction in the occurrence of "polypharmacy", and an increasing emphasis on crisis prevention planning, and wellness planning.

- "Peer Support in Aftercare" moved into its second phase, during which the SFY02 initial program model was successfully maintained in addition to it being replicated in a new region with a new clubhouse and new inpatient facility.

- "Improving Special Populations Access to the Acute Treatment Services (ATS) for Substance Abuse" resulted in the development of an Enhanced – ATS. The initiative involved the collaborative efforts of the Division, the Partnership, DPH, and DMH in implementing programmatic specifications derived from the principles of the Community Consensus-Building Collaborative to address the unique needs of the dually-diagnosed (MH/SA) in need of acute care services.

Quality Improvement and Advisory Council Meetings: In SFY03, The Partnership continued a number of Councils that meet periodically throughout the year. In SFY03, there was a continuing emphasis placed upon developing and maintaining interaction between the various councils. Conjoint council meetings are scheduled throughout the year.

The MBHP Advisory Council (formerly known as the Quality Improvement Council), meets quarterly, and is comprised of representatives from the Division, DMH, the Partnership and representatives from consumer, family and clinical advisory councils. This council provides a forum at which to discuss high-level issues that cut across departmental and public/private sector lines, and to identify opportunities for programmatic improvement.

The Family Advisory Council meets monthly to engage in discussions of program information, helping monitor the contractors performance with special emphasis placed on behavioral health care services provided to families and children. This council is made up of family members of adults and children either biologically related, in a foster care arrangement or in an adoptive family. This group includes representatives from the Division, DSS, the Massachusetts Chapter of the National Alliance of the Mentally Ill, and the Parent/Professional Advisory League. In SFY03 a joint session of the Family and Consumer councils took place. The meeting included the Division's Medical Director and Pharmacy Program Director, and the subject matter focused upon the upcoming changes to the DMA pharmacy policies and procedures.

The Division's *Consumer Advisory Council* has been meeting since the contract's inception, and meets on a monthly basis. This group of approximately 20 behavioral health care service consumers reviews programmatic information, offers advice and suggestions for consumer focused performance standards, and help to monitor the contractor's progress toward annual improvement goals. The Division and DMH have representatives within this council. In SFY03, a council workgroup developed and delivered a proposal that was eventually incorporated as one of the selected performance incentive initiatives for FY04.

A *Behavioral Health Advisory Council* continued throughout SFY03 with representatives from the DMH, the Division, trade organizations, academia, and consumer and family members. The Behavioral Health Advisory Council meets every other month. The goal of this group is to review programmatic information, assimilate that information with the knowledge from their diverse range of experiences, and offer constructive criticism about the Behavioral Health Program to the Contractor and the Division.

The *Behavioral Health Clinical Advisory Council* is comprised of local area practitioners who represent various cultural/ethnic groups and various service types within the mental health and substance abuse treatment community. The Council is chaired by the BH Program Medical Director, and meets at least quarterly to address a variety of clinical and administrative issues. A conjoint meeting with the PCC Clinical Advisory council is held once a year to address issues of shared concern. The Behavioral Health Clinical Advisory Committee assists in the development and implementation of clinical and level-of-care guidelines.

Alerts: Alerts are high-level policy directives distributed by the Partnership to all network providers with a goal of improving services. For example, in SFY03, an alert was issued on the implementation of the Comprehensive Family Focused Care initiative a new multi-agency blended funding approach to a highly coordinated model for delivering home and community based services for children and families with complex treatment needs.

MCO Quality Improvement and Measurement Activities: The MCO program continues to focus its quality improvement and measurement activities in four areas: MCO contract status meetings, member satisfaction surveys, HEDIS measures, and clinical topic reviews. HEDIS, member satisfaction survey activities and CTR for the MCO Program are conducted in conjunction with the PCC Plan and Behavioral Health Program and are addressed below.

Contract Status Meetings: Organized meetings between each MCO and Division staff, known as Contract Status Meeting (CSMs), are held twice annually to assess the MCO's performance on negotiated quality improvement goals. The Division works with the MCOs to negotiate Standard and Plan-specific quality improvement goals. These goals are included as an attachment to the MCO contracts. During SFY03, the Division extended this cycle to an 18-month rather than an annual cycle in preparation for reprocurement of the contract. The Division will hold two CSMs during this 18-month cycle (January, 1, 2003 – June 30, 2004). CSMs are to be held in September and April for the SFY03-04 cycle. The April meeting will culminate in the Division scoring each MCO's performance relative to meeting quality improvement goals, as well as on other contract management and reporting requirements. In reviewing MCO performance, the Division involves a team consisting of MCO staff, Behavioral Health and certain PCC Plan staff, primarily those with expertise relevant to the clinical and quality improvement initiatives undertaken by some of the MCOs to evaluate MCO performance.

Standard Improvement Goals: During SFY03, the MCO program continued to negotiate standard quality improvement goals in selected areas, which all contracted MCOs must address. The Division supported the MCOs' efforts on these Standard goals by convening and leading MCO workgroup meetings regularly throughout the year. Standard goals for the 18-month 2003-2004 cycle are:

- Maternal Child Health*:* The maternal and child health goal was designed as a multi-year effort of focused interventions designed to improve the health status of pregnant women, children, and adolescents enrolled with MassHealth MCOs. Improvement will be achieved by (1) increasing the percentage of pregnant women receiving timely and adequate perinatal care to 85%, (2) increasing the percentage of fully immunized 2 year old children to 72% for HEDIS Combination 2, and (3) increasing the percentage of adolescents (ages 12-18) receiving appropriate and regular anticipatory guidance by increasing Adolescent Well Care Visits to 60% and participating in the Division's "MAAGPAC" initiative described in the PCC Plan section.

- Special Populations: The Special Population Goal is a multi-year effort to develop interventions to identify MassHealth members with special needs, in

order to understand and better meet their needs. The SFY03 goal is designed to help MCOs understand the impact of care and disease management systems on providers, and members, and to improve such systems as needed through;

1) working collaboratively with staff from the other MassHealth contracted MCOs and the Division to identify specific opportunities to improve physician awareness and use of MCO care management programs for members with special needs;
2) implementing interventions to impact specific issue(s) related to the delivery of health care by the MCO for a particular population; and
3) improving the processes for identifying enrollees with special needs and ensuring their receipt of care management when needed and appropriate.

- Behavioral Health: In SFY03 the goal requires each MCO to review data and evaluate how members' medical care and behavioral health care are integrated. Through this goal, MCOs must monitor and improve specific aspects of Behavioral Health/PCP (Medical) Integration and pharmacy utilization. The SFY03 Goal also requires MCOs to complement their current and ongoing Behavioral Health Quality Improvement efforts with consumer driven principles of rehabilitation and recovery. MCOs will be required to demonstrate how they will incorporate rehabilitation and recovery in order to promote behavioral health programs that support consumer recovery and empowerment.

Individual Plan-specific Goals: In addition to the Standard Improvement goals, the Division negotiated two plan specific goals with each MCO. MCO specific improvement goals varied significantly and addressed clinical initiatives, and/or care management for specific special populations. Examples of the individual plan goals include: pediatric and adult asthma, diabetes, tobacco cessation, cultural competency, and preventive care.

MCO Performance Monitoring Project: The MassHealth Program, along with 5 other states and Washington, DC, participated in a series of Technical Assistance Workshops offered by the Center for Health Care Strategies to "build a successful and strategic performance monitoring system" for Medicaid and SCHIP Programs.

The MCO Program within the Office of Acute and Ambulatory Care asked CHPR to assist with the development of the performance monitoring report. Version 1.0 of the chart book was designed for internal use by the MCO program. Future versions will focus the number and types of charts for specific audiences, e.g. the MCOs, EOHHS leadership, the legislature. Four types of performance measures in 7 performance domains were included the report. The types of measures consisted of accountability measures (are the plans performing as expected on access, quality and cost?), early warning measures (are there potential problems

or opportunities for improvement?), best practices (areas where one or more plans excel?), and value (worth of managed care relative to local and national benchmarks). The domains were: demographics, member satisfaction and service, cost and utilization, financial stability, access to care, quality of care, and disease management/care management.

Evaluation of DMA Rating Categories III and IV: Rating Categories (RC) III and IV provide for specialized managed care services to people with active or advanced AIDS (RC III) and severe physical disabilities (RC IV) and have been programs of the Division of Medical Assistance since the inception of MassHealth Managed Care in 1992.

The purpose of this project is to evaluate a model of care that provides specialized care coordination for medically complex MassHealth members who meet the Division's specified enrollment criteria. The main goals of the evaluation project are to assist the Division's Office of Acute and Ambulatory Care in a) determining the cost and effectiveness of this model of coordinated care compared to 'non-managed' care for PCC plan members with similar characteristics, b) assessing promising practices that could be applied to other populations with special needs, and c) informing decision making about the future of the RC III and RC IV programs in the context of the current challenging fiscal environment and the upcoming re-procurement of the MCO contracts.

The Division has asked CHPR to conduct a comprehensive evaluation of the RC III and RC IV programs. The evaluation will respond to the Divisions need for cost and program impact information to inform the managed care organization re-procurement process. A preliminary Phase I report has been delivered to DMA, with a final report due mid-October 2003.

Provider Services Update:

MassHealth Provider Services Call Center: From July 1, 2002 to June 30, 2003, MassHealth has made significant strides to enhance and expand the level of customer service offered to providers. Very often the first call from a provider will be to the MassHealth Provider Services Call Center. The Call Center has moved closer to the Division's goal, to ensuring that 95% of all calls received are answered and to significantly reduce the average wait time for each provider. The Call Center answered over 240,000 calls and reduced the average wait time to less than one minute. In addition we have restructured the unit to provide additional support to providers and staff have undergone testing and retraining to ensure accuracy of the information we given to providers.

Provider Training: During SFY03 providers participated in 226 training events. Of these, the majorities were provider specific trainings for individual providers and included face-to-face meetings and extensive telephone visits. The majority

of these training requests were received through the MassHealth Provider Services Call Center. One on one meetings are scheduled for providers needing general billing training. Telephone visits are held when a provider requests a block of time to address a specific area of concern such as billing for Medicare/MassHealth crossover claims, or the eligibility verification process.

In SFY03, materials were redesigned to focus on business process improvements undertaken by the Division as well HIPAA. Providers Services continue to focus on measuring improvement in billing as a result of the training. The provider website was implemented expanding distribution of educational materials such as: billing tips flyers, a comprehensive frequently asked questions, and provider-type specific materials are all available for download. In the coming year, plans to continue provider services using the website as an avenue for communication and also plan are to improve self- service capabilities for providers by adding more downloadable materials.

Training efforts in SFY03 continued to include provider visits, phone calls, large-scale group training (such as when a regulation changes), new provider training, and ongoing contact with provider associations statewide, and HIPAA educational forums. Provider types included in targeted trainings were; dental, adult foster care, group adult foster care, physician, and PCA. The provider groupings that were selected for training typically had a change in billing requirements or had been identified as a group that were encountering a higher than average number of billing issues. During the year providers services also participated with CMS and provider associations in statewide provider trainings focusing on HIPAA. These meetings hosted by MassHealth brought together participants from other payer organizations, MassHealth vendors and the provider community. In addition to giving providers an opportunity to meet with these organizations the meetings included informational workshops including such topics, as HIPAA 101, HIPAA Transactions & Testing, and Best Business Practices and Updates from CMS. Over 500 providers attended these meetings, which took place throughout Massachusetts.

Throughout the year provider services continued to expand services to new providers. In addition to conducting bi-monthly new provider trainings, individual consultations were also offered after this meeting for providers who had more specific needs. Provider Services also began the process of redefining the new provider training by targeting only new providers. In the past every provider who had changed their provider number was contacted even if they were not a new provider. Targeting only new providers for this orientation and providing a separate training forum for experienced billers better meets the providers' needs.

Research & Support: In addition to provider training activities in the past year, provider services continued to expand our research and support services to the provider community. The Research and Support team was created to provide an extra layer of customer service for the provider community. They are assigned

referrals not only from the Call Center but also other internal departments at Unisys, Division staff, and other Division vendors such as the Partnership and Maximus. Last year the research team completed 1,264 referrals. This team also offers on-going support to certain provider populations who require additional assistance such as reviewing claims weekly for all Private Duty Nurse Providers and contacting them weekly to provide billing assistance.

In addition to Training and Support activities, the Division continues to provide information to providers through several channels including message text on remittance advices and the creation of new informational flyers. The publications team issued four provider newsletters that mostly focused on the implementation of HIPAA. In addition 1,061 publication requests were filed for copies of bulletins, transmittal letters, etc.

HIPAA Support Team: Much of the activities were focused on a successful implementation of HIPAA. The small Electronic Claims Services (ECS) unit was transitioned to a larger HIPAA Support Center. The organizational structure was refined to include a new call center with a new toll free number where providers can get immediate access to assistance. In February the Center began accepting claims from dental providers in the new HIPAA format. Staff actively participated on five important workgroups responsible for guiding the HIPAA implementation to a successful conclusion.

HEDIS: HEDIS is a standardized measurement and reporting strategy for health plans and managed care organizations, directed by the National Committee for Quality Assurance (NCQA). The Division uses a subset of HEDIS measures on a rotating basis to assess the performance of the contracted capitated MCO, and the PCC Plan. The Division's rotation-of-measures strategy continues to evolve.

HEDIS 2002 focused on childhood and adolescent immunizations, well child care visits, children's access to PCPs, and comprehensive diabetes care. The MassHealth HEDIS 2002 (Reporting Year 2001) Report was completed in December 2002.

The analysis and report of data collected for HEDIS 2003 will be completed by mid-November 2003. The data includes the results of the perinatal care, cervical cancer screening, breast cancer screening, behavioral health utilization, and the antidepressant medication management measures.

For the fifth consecutive year, MassHealth submitted HEDIS measurement data for their plans as part of the American Public Human Services Association (APHSA) Medicaid HEDIS Benchmarking Project to create a national database of Medicaid HEDIS data.

Independent External Review: In SFY03 the Division contracted with CHPR at the University of Massachusetts Medical School to perform the MCO Independent External Quality Review for the MCO Program and the PCC Plan. Previously this study was only conducted with the MCOs, during SFY03 the Division began also including the PCC Plan in this study. Massachusetts Peer Review Organization (MassPRO) conducted the medical record review related to the selected clinical topics, under a subcontract managed by CHPR. The Division refers to this independent external review as the Clinical Topic Review (CTR). Topics for SFY03 include Perinatal Care and Depression in the Community.

EPSDT: In FFY02 the Division reported an EPSDT participation ratio of 66%, a comparison of the number of children and adolescents who were due to receive a screen within the reporting period with the number who actually received a visit. Due to the claims lag, the EPSDT numbers for FFY03 are not yet available.

The number of claims found for reporting referral services and dental services increased from last year's report. The number of lead screenings completed increased by almost 6,000 tests even with a decrease in eligibility and fewer children who were eligible to receive the test. Since there were no programming changes between last year and this year's report that can be attributed to these changes, it seems reasonable to assume that this data reflects either actual increases in care delivery or increased efficiency in provider billing for these services.

Member Survey: Historically, the Division conducted an annual MassHealth Member Survey for the purpose of eliciting member feedback in a number of areas including availability and access to services, utilization and experience with health services, as well as member satisfaction with the services delivered by their health plan or provider. In 2003 the Division received approval of an amendment to Term and Condition Number 15 of its 1115 waiver that allows a survey of MassHealth managed care members enrolled in either the PCC Plan or an MCO every other year rather than annually. The reasons for this schedule change from an annual survey include: consistency of the results of the surveys since 1998 indicating that members in all plans are highly satisfied with their experience of care; overall ratings since 1998 with little variation from year to year or from plan to plan; few findings are statistically significant; and statewide financial constraints continue to exist. As a result of this amendment, activities this year have focused on planning for the 2004 MassHealth Member Survey.

Measuring Patient's Experience with Their Primary Care Physician Pilot: The PCC Plan and six commercial health plans participated in a pilot project sponsored by MHQP and The Health Institute at New England Medical Center to study the primary care experience of Massachusetts adults. A central objective of the project is to develop a single agreed-upon survey instrument that could be

used by all health plans. The project surveyed 45,000 adult patients from the practices of 200 Massachusetts physicians. Hopefully, PCC Plan participation will provide useful information for measuring experiences of MassHealth members with their primary care provider.

Encounter Data: The Division forwards to CMS the Minimum Data Set (MDS) for the Encounter Data Project annually. To date, the Division has submitted the following Minimum Data Sets to CMS: (1) the FY 1998 data was submitted to CMS, July 1999; (2) the FY 1999, including a refreshed MDS for FY 1998, was submitted July 2000; (3) FY00 data was submitted in July 2001; and (4) FY01 data was submitted in July 2002; and (5) FY01 data was submitted in July 2003.

As part of the 1115 Demonstration Waiver, the Division is required to collect and report on standardized and validated encounter data to CMS for each of its managed-care programs. These managed-care programs include the PCC Plan, the Behavioral Health Program (BHP), and the MCO Program. The Division directly collects and maintains encounter data from the PCC Plan. The Behavioral Health Program is required to submit encounter data to the Division on a monthly basis. During SFY02, the Division ended its contract with a vendor, The MEDSTAT Group, to collect and maintain encounter data from the MCOs and brought these functions in-house in order to increase the Division's ability to conduct analyses of the MCO encounter data and to compare it with the PCC Plan claims data. The MCOs are required to collect and maintain 100% of encounter data at the plan level for all MCO-Covered Services. Such data must be able to be linked to MassHealth eligibility data. MCOs are required to submit their encounter data biannually and are required to submit one encounter for each service performed. To assist the MCOs, the Division and MEDSTAT, collaboratively developed specifications for the Encounter Data Set, which all MCOs are required to adhere to. The goal of the specifications is to clarify the standard record layout, format, and values that will be considered acceptable to the Division. With the encounter data analysis functions moved in-house, the MCOs continue to follow these specifications.

The Division performs a thorough assessment of data accuracy and completeness on the encounter data. The Division performs detailed data quality testing of the encounter data for the PCC Plan, the Behavioral Program and the MCO Program. The Data Quality Review Process includes the following components: initial quality assurance checks for each managed-care program; production of a Data Quality Report for each managed-care program; and production of a Data Quality one-page summary for each managed-care program.

As part of the ongoing Data Quality Process, the Division meets with the health plans twice a year to discuss issues from the Data Quality Report. Discussed at the meetings are data fields that fail to meet the Division standards, the reasons

as well as plans to correct the issue for future submissions. Also discussed are any other data issues discovered in the course of using the data as well as a review of invalid values from the data quality reports and data conversion errors. If necessary, plans will be asked to resubmit data.

On an annual basis, the Division also submits to CMS the MDS for the MCOs, as well as the encounter data from the Behavioral Health Program contractor. On a quarterly basis, the Division submits to CMS encounter data for the PCC Plan and the wrap-around services for the MCO Program through its Medicaid Statistical Information System (MSIS). The wrap-around services for the MCO Program represent those services required by the MDS that are paid for directly by the Division.

In accordance with CMS's requirement, the Division also submits to CMS 100% encounter data on selected clinical indicators. The Division has, to date, submitted the following measures and plans to submit future measures in July of each year.

- July 1998 Submission: Pediatric well visits
- July 1999 Submission: Pediatric Asthma Measures
- July 2001 Submission: Well-Child visits and utilization
- July 2002 Submission: Well-Child visits and utilization and Pediatric Asthma Measures
- July 2003 Submission: Well-Child visits and utilization and Pediatric Asthma Measures

IX. Financial Report

The Annual Financial Report will be submitted to CMS under a separate cover.

X. Other Topics of Interest

Grievances

PCC Plan
In SFY03, MassHealth members filed 27 grievances against PCCs, PCC practices, or PCC office staff.

MCO Program
In SFY03, MassHealth members filed 157 grievances against MCOs. (Note: this is a substantial drop from the total reported in last year's annual report, which could be attributed to the actions by some MCOs to improve identification and categorization of grievances as well as through improving their internal processes such that grievances are prevented in the first place.)

Behavioral Health
Behavioral health complaints, grievances and appeals are tracked separately.

The PCC Plan's BHP reported receiving 129 complaints, 0 grievances, and 8 appeals filed. The MCO's BHPs reported receiving 66 complaints, 2 grievances, and 21 appeals filed.

Appeals

In FY03, there were a total of 8,136 eligibility appeal decisions rendered by the Board of Hearings for the Demonstration population. The majority of the appeals, 7,017 or 86%, were closed by dismissal. Approximately 8% were approved, 10% were denied, and 2% were approved in part/denied in part.

MassHealth Members: June 1997, 2001, 2002 and 2003

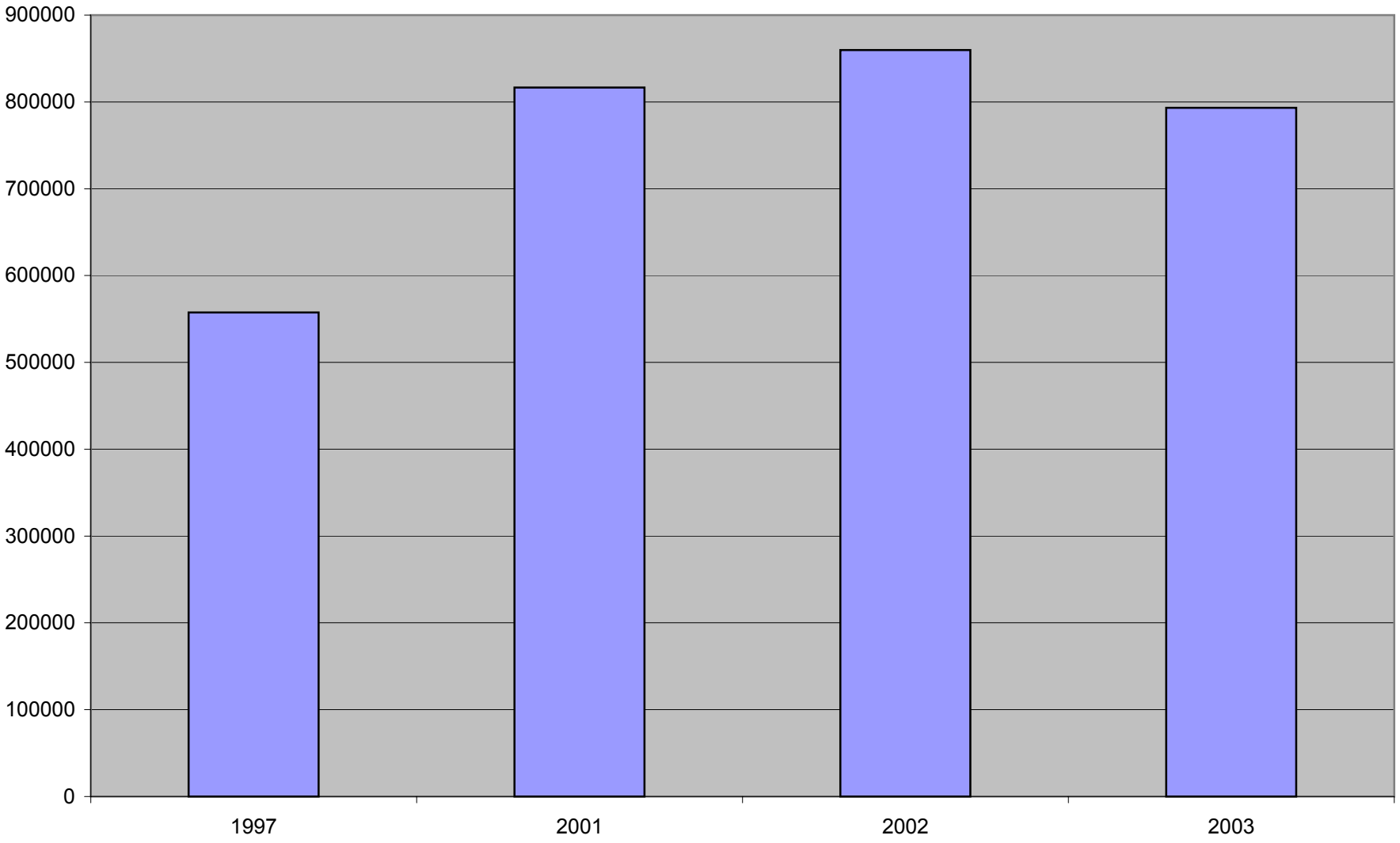

Chart1

1997	2001	2002	2003
557372	816,483	859,818	793,224

Distribution of MassHealth 1115 Demonstration Population by Eligibility June 30, 2003

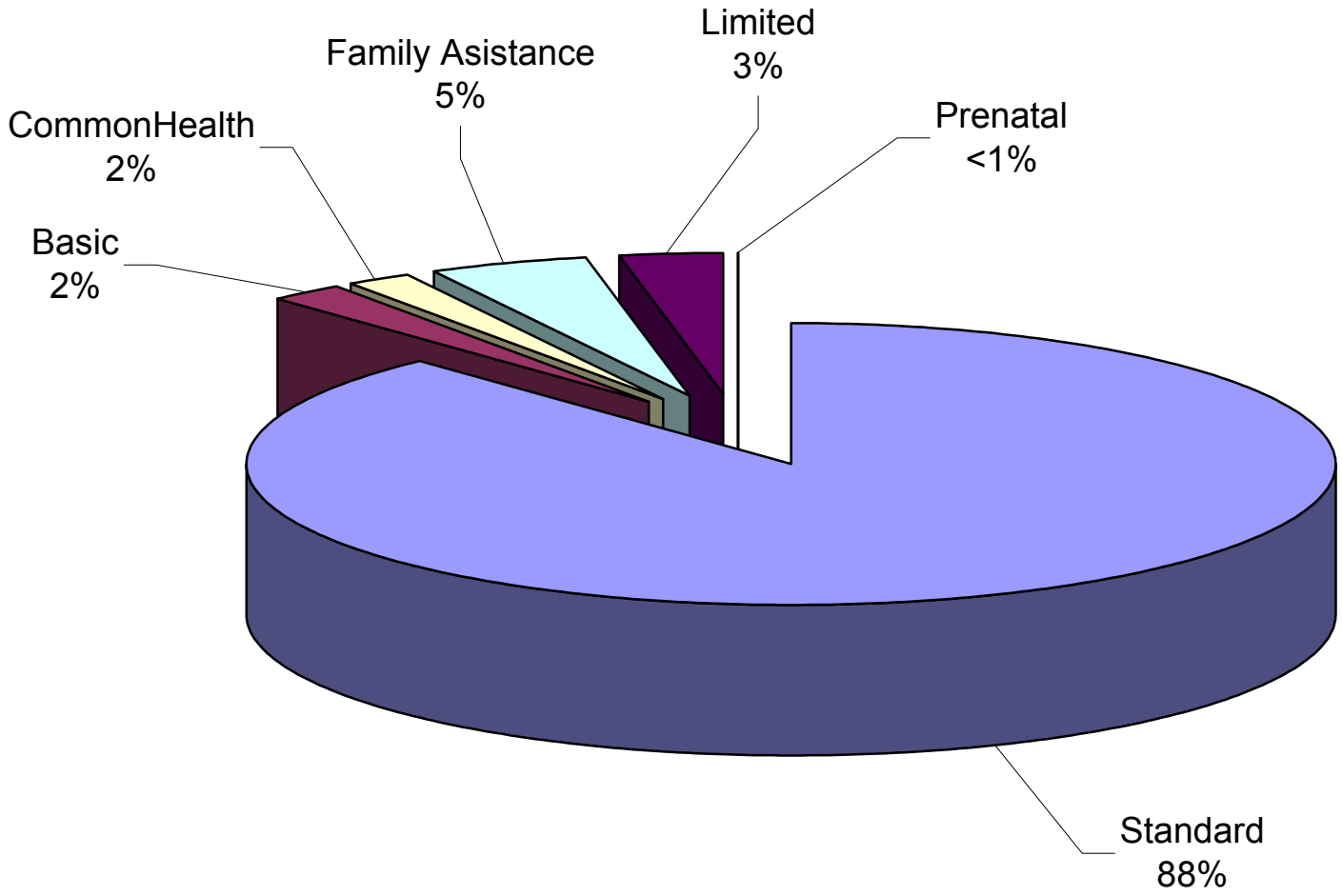

Chart2

Standard	697,869
Basic	18,584
CommonHealth	14,871
Family Asistance	36,922
Limited	24,564
Prenatal	414

Policies Purchased through the Insurance Partnershipand Family Assistance Programs as of June 2003 by Policy Type (N= 7,379)

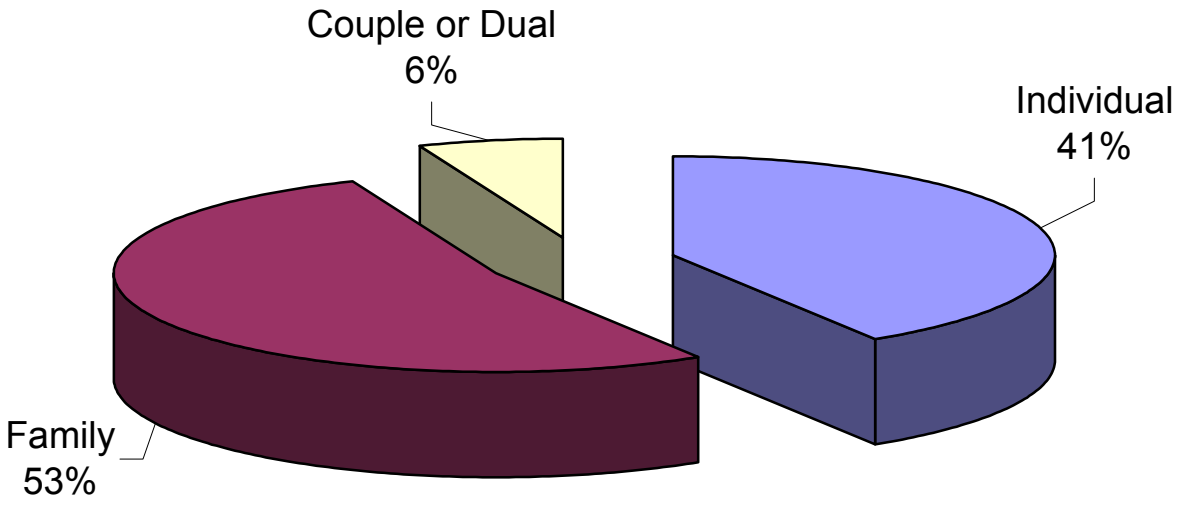

Chart3

Individual	41
Family	53
Couple or Dual	6
	100

Covered Lives under the Insurance Partnership
as of June 2003
(N= 18, 646)

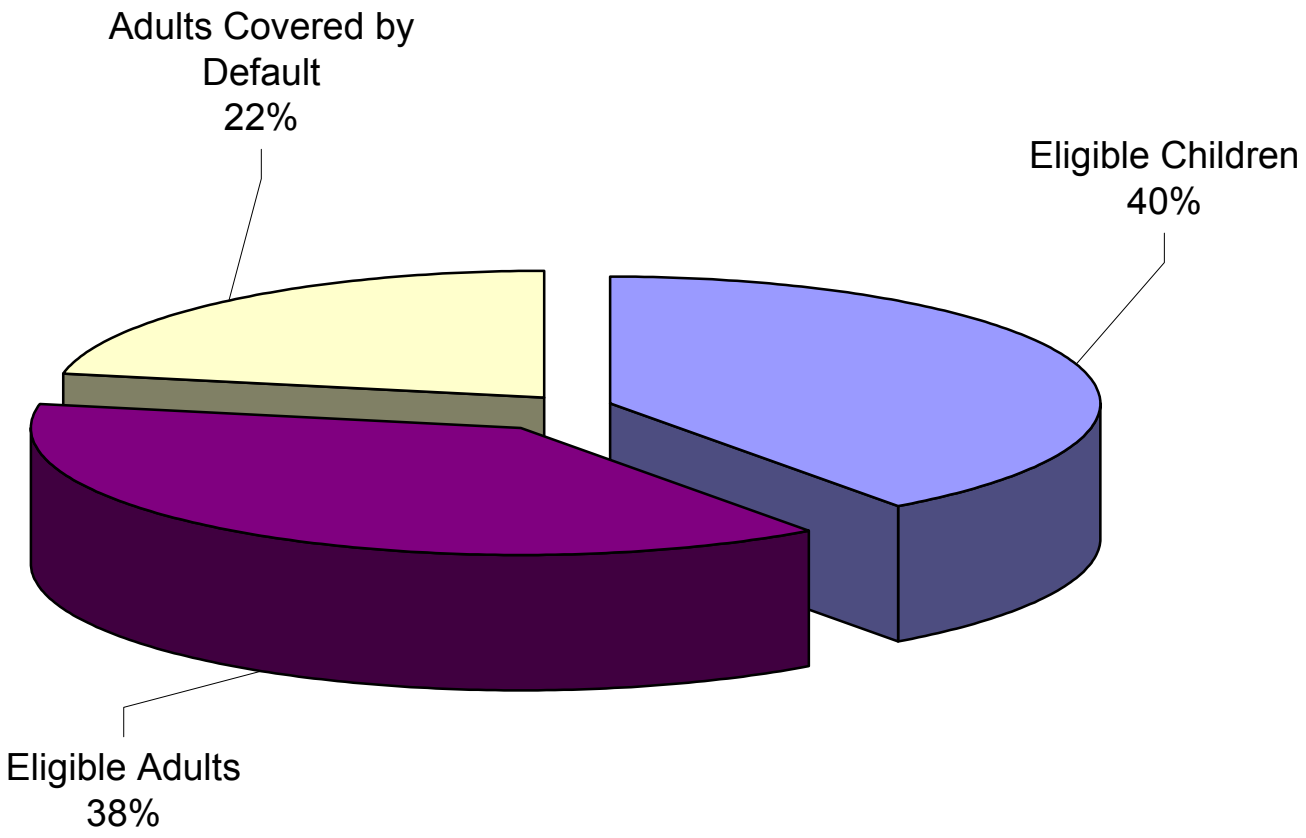

Chart4

Eligible Children	40
Eligible Adults	38
Adults Covered by Default	22
	100